

# WorkCover NSW – certificate of capacity

Please ensure all sections are completed. Tick if this is the initial certificate for this claim ☐

## PART A – MAY BE COMPLETED BY PATIENT

Patient's first name	Last name
<input type="text"/>	<input type="text"/>
Date of birth (DD/MM/YYYY)	
<input type="text"/>	
Patient's address	
<input type="text"/>	
Claim number	
<input type="text"/>	
Medicare number	
<input type="text"/>	
<b>Shaded areas to be completed for initial certificate only</b>	
Patient's occupation/job title	
<input type="text"/>	
Employer's name and contact details	
<input type="text"/>	
I consent to my treating medical practitioner, my employer, the insurer, other treating practitioners, workplace rehabilitation providers and WorkCover exchanging information for the purposes of managing my injury and workers compensation claim. I understand that this information will be used by WorkCover and insurers to fulfil their functions under the workers compensation legislation.	
Signature of patient	Date (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>

## PART B – TO BE COMPLETED BY NOMINATED TREATING DOCTOR OR TREATING SPECIALIST MEDICAL PRACTITIONER

### MEDICAL CERTIFICATION

Diagnosis of work related injury/disease
<input type="text"/>
Patient stated date of injury <input type="text"/>
<b>Shaded areas to be completed for initial certificate only</b>
Patient was first seen at this practice/hospital for this injury/disease on <input type="text"/>
Injury/disease is consistent with patient's description of cause <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain
How is the injury/disease related to work?
<input type="text"/>
Detail any pre-existing factors which may be relevant to this condition
<input type="text"/>

Claimant name  Claim number

## MANAGEMENT PLAN FOR THIS PERIOD

Treatment/medication type and duration (Duration: short term = < 6 weeks, medium term = 6–12 weeks, long term = > 12 weeks)

Referral to another health care provider (provide details of provider and service requested, duration and frequency when relevant)

## CAPACITY FOR EMPLOYMENT (Please consider the health benefits of work when completing this section)

Do you require a copy of the position description/work duties? ☐ Yes ☐ No

Patient:

☐ is fit for pre-injury duties

☐ has capacity for some type of employment from / /  to / /   
for  hours/day  days/week

☐ has no current work capacity for any employment from / /  to / /

If no current work capacity, estimated time to return to any type of employment

Factors delaying recovery

Do you recommend referral to workplace rehabilitation provider? ☐ Yes ☐ No

**Capacity** – If the patient is fit for pre-injury duties this section does not need to be completed. For all other patients please consider activities of daily living currently being performed.

Lifting/carrying capacity

Sitting tolerance

Standing tolerance

Pushing/pulling ability

Bending/twisting/squatting ability

Driving ability

Other (please specify) eg psychological considerations, keep wound clean and dry

Next review date / /  (if greater than 28 days, please provide clinical reasoning)

Comments

## TREATING MEDICAL PRACTITIONER DETAILS

☐ Please tick if you agree to be the nominated treating doctor for the ongoing management of this worker's injury and return to work.

I certify that I am the ☐ nominated treating doctor or ☐ treating specialist or ☐ other\* (please tick) and I have examined this patient. The information and medical opinions contained in this certificate of capacity are, to the best of my knowledge, true and correct.

Signature

Date (DD/MM/YYYY)

/ / 

\*If 'other', please specify

Name

(practice stamp if available)

Address

Telephone number

Provider number

Worker's first name

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/  /

[illegible]

engaged in any form of paid employment, self employment or voluntary work for which I have received or am entitled to receive payment in money or otherwise since the last certificate was provided, that I have not yet declared to the insurer.

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