Form 3

WorkCover WA – FIRST certificate of capacity

1. WORKER'S DETAILS

First name | Last name

Date of birth | Email

Phone | Mobile

Address

2. EMPLOYMENT DETAILS

Worker's job title | Employer's name

Employer's address

3. CONSENT AUTHORITY

I consent to any medical practitioner who treats me (whether named on this certificate or not) to discuss my medical condition with my employer, insurer and other medical or allied health professionals for the purpose of my claim for workers' compensation and return to work options.

Worker's signature | Print name

Date

4. WORKER'S DESCRIPTION OF INJURY

Date of injury

What happened?

Worker's symptoms

5. MEDICAL ASSESSMENT

Date of this assessment

Clinical findings NA

NA

Diagnosis

The injury is consistent with worker's description of how injury occurred ☐ yes ☐ no ☐ uncertain

The injury is: ☐ a new condition ☐ a recurrence of a pre-existing condition

6. WORK CAPACITY

Worker's usual duties

Having considered the health benefits of work, I find this worker to have:

- ☐ **full capacity for work** from ____ ☐ but requires further treatment
- ☐ **some capacity for work** from ____ to ____ performing:
  - ☐ pre-injury duties ☐ modified or alternative duties ☐ workplace modifications
  - ☐ pre-injury hours ☐ modified hours of ____ hrs/day ____ days/wk
- ☐ **no capacity for any work** from ____ to ____ *(outline clinical reason below)*

Worker has capacity to:

(Please outline the worker's physical and/or psychosocial capacity – refer to explanatory notes for examples. Where there is no capacity for work, please provide clinical reasoning)

- ☐ lift up to ____ kg
- ☐ sit up to ____ mins
- ☐ stand up to ____ mins
- ☐ walk up to ____ m
- ☐ work below shoulder height

7. INJURY MANAGEMENT PLAN

Activities/interventions	Purpose/goal *(likely change in symptoms, function, activity and work participation)*

I would like: ☐ more information about available duties ☐ a RTW program to be established ☐ to be involved in developing the RTW program

Examples of injury management activities/interventions include:

- *further assessment - diagnostic imaging, medical specialist consults, worksite assessment*
- *intervention - physiotherapy, clinical psychology, exercise physiology, prescribed medications, workplace mediation*
- *return to work planning - identify suitable duties, establish return to work program*

8. NEXT REVIEW DATE

- ☐ Worker does not need to be reviewed again (FIRST and FINAL certificate of capacity)
- ☐ I will review worker again on ____ *(If greater than 14 days, please provide clinical reasoning)*

Comments

9. MEDICAL PRACTITIONER'S DETAILS

Name

Address

Phone

Fax

(Practice stamp – optional)

AHPRA no. MED

Email

Signature

Date