Form

Statement of fitness for work – Progress certificate

Recommended for a maximum 28 days duration

Note: maximum referral period for rehabilitation treatment prior to review is initially 14 days, and then 28 days subsequent referrals to the same discipline.

- *Medical practitioner to retain a copy*
- *This statement to be given to worker*

1. Worker details						
Surname:						
Given names:						
Date of birth:		Date of injury or disease:				
Address:						
Suburb:		State:		Postcode:		
Home number:		Work number:				
Mobile number:		Email address:				

2. Employer details					
Employer name:					
Address:					
Suburb:		State:		Postcode:	

3. Medical assessment			
Date of examination:		Time of examination:	AM ☐ PM ☐
Clinical findings / diagnosis at this examination:			

4. Fitness for work (tick only those boxes which apply)							
In my opinion that as from the date of this statement, the worker is:							
Fit to return to ***pre-injury duties, no further treatment*** required.							☐
Fit to return to ***pre-injury duties***, but ***requires further treatment***							☐
Fit to return to work for restricted hours / days from:							☐
	to	(inclusive)	hours per day		hours per week		
Fit to return to work **<u>on restricted duties</u>** from:		to				(inclusive)	
Restricted duties:	Avoid prolonged standing / walking / sitting						☐
	Avoid squatting / kneeling / ladders / steps						☐
	No lifting anything heavier than:	5kg ☐	10kg ☐	15kg ☐	20kg ☐		☐
	Avoid repetitive use of affected body part						☐
	Avoid repetitive bending / lifting						☐
	Other (please specify)						☐
Totally unfit for work from:		to				(inclusive)	☐
I will review the worker (date of next appointment):							

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5. Injury management (tick only those boxes which apply)						
Medical practitioner / employer contact						
I have made contact with the employer and discussed alternative work options						☐
The worker will require more than three days off work, consequently I will be happy to discuss this further with the employer / insurer.						☐
Preferred contact days and time:	Monday ☐	Tuesday ☐	Wednesday ☐	Thursday ☐	Friday ☐	
	Saturday ☐	Sunday ☐	Times:	AM	OR	PM
Medical management plan						
Treatment (specify):						☐
Medication (specify):						☐
Referred to specialist: (specialty/name):						☐
Date of appointment:		Time of appointment;		AM ☐	PM ☐	
Referred to hospital (specify):						☐
Referred to Allied Health Professional(s):						
Physiotherapist name:		Number of sessions recommended				
Chiropractor name:		Number of sessions recommended				
Other (specify):						
Vocational rehabilitation – options must be discussed with the worker						
Likely to be necessary, subject to review in		weeks				☐
I would like the employer / insurer to organise a referral and discuss with me.						☐
Preferred contact days and time:	Monday ☐	Tuesday ☐	Wednesday ☐	Thursday ☐	Friday ☐	
	Saturday ☐	Sunday ☐	Times:	AM	OR	PM

Medical practitioner details					
Name:			Registration number:		
Address:			Suburb:		
State:		Postcode:		Work number:	
Fax number:		Email address:			
Signature:			Date:		