



WorkCover WA – FINAL certificate of capacity

FORM 4

1. WORKER'S DETAILS

First name	<input type="text"/>	Last name	<input type="text"/>
Date of birth	<input type="text"/>	Claim no.	<input type="text"/>
Phone	<input type="text"/>	Email	<input type="text"/>
Address	<input type="text"/>		

2. EMPLOYER'S DETAILS

Employer's name	<input type="text"/>	Employer's phone	<input type="text"/>
Employer's address	<input type="text"/>		

3. MEDICAL ASSESSMENT

Date of this assessment	<input type="text"/>	Date of injury	<input type="text"/>
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☐ The worker's condition is unlikely to change substantially in the next 12 months

4. WORK CAPACITY

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

☐ **full capacity for work** from ☐ but requires further treatment (*outline specifics below*)

☐ **capacity for work** performing hours per day and days per week from
as outlined below: (*Please outline the worker's physical and/or psychosocial capacity for work, functional limits, ongoing need for workplace modifications, and/or further treatment needs*)

<input type="checkbox"/> lift up to <input type="text"/> kg	<input type="text"/>
<input type="checkbox"/> sit up to <input type="text"/> mins	<input type="text"/>
<input type="checkbox"/> stand up to <input type="text"/> mins	<input type="text"/>
<input type="checkbox"/> walk up to <input type="text"/> m	<input type="text"/>
<input type="checkbox"/> work below shoulder height	<input type="text"/>

☐ **The worker's incapacity is no longer a result of the injury**

5. REASON FOR CAPACITY/INCAPACITY

Please outline your clinical reason for the worker's capacity/incapacity:

<input type="text"/>
<input type="text"/>

6. MEDICAL PRACTITIONER'S DETAILS

Name	<input type="text"/>	AHPRA no. MED	<input type="text"/>
Address	<input type="text"/>	Email	<input type="text"/>
	<input type="text"/>	Signature	<input type="text"/>
Phone	<input type="text"/>		
Fax	<input type="text"/>	Date	<input type="text"/>

(Practice stamp – optional)