

Work Capacity Certificate



A. Patient and employer details

Family name: Given names:
Claim number (if known): Employer name:
Date of birth:

B. Injury details and assessment

I examined you on: for injury(s)/condition(s) you stated occurred/developed on:
The stated cause was:

The injury(s)/condition(s) you presented with is/are consistent with your stated cause(s): Yes No
New condition Recurrence of pre-existing condition

My clinical diagnosis/es based on my examination of you and other available information is:

Other comments/clinical findings:

C. Certification



In my opinion, you: (please tick whichever apply)

- ☐ have recovered from your injury/condition and are fit to return to your normal duties and hours on:
☐ some further treatment may be required
☐ are fit to perform suitable duties that accommodate your functional abilities from: to
☐ are medically unfit to undertake suitable duties while recovering from your injury for the period: to

Note: Certification based on functional capacity, not available duties.

Reason:

☐ I estimate you should have functional capacity to return to work in days weeks **OR** ☐ uncertain at this stage
(estimated timeframe will assist with planning for return to safe work)

I would like to review your progress on: or ☐ at your next medical consultation

Comments:

D. Treatment plan



The following treatment plan is aimed at assisting your recovery and return to work:

I have referred you for the following clinical treatment:

- ☐ Medical specialist (Name & specialty)
☐ Psychologist (Name)
☐ Physiotherapist (Name)
☐ Other (Name & discipline)

E. Functional ability



Your ability to work is affected by **this** injury(s)/condition(s) as follows:

(please select applicable functions – blank fields indicate that limitations don't apply. Please include any impact of medications on function)

☐ No restrictions

Physical function

Can

With modifications

Cannot

Sitting:

Standing/walking:

Kneeling/squatting:

Carrying/holding/lifting:

Reaching above shoulder:

Bending:

Use of affected body part:

Neck movement:

Climbing steps/stairs/ladders:

Driving:

Comments

(e.g. details of capacity or limitations that will assist in identification of suitable duties)

Mental health function

Not affected

Partially affected

Affected

Attention/concentration:

Memory (short term and/or long term):

Judgement (ability to make decisions):

☐ **Other functional considerations** - not listed above
(please provide details in comments section)

☐ I have prescribed medication(s) that could impact upon your ability to undertake some activities.

Details:

I recommend:

☐ A graduated increase in working hours over weeks from hours a day to your normal hours/ hours a day

☐ Non-consecutive working days for a period of days or weeks

☐ I would like more information about the options available for your return to work

☐ I would like a copy of your recovery and return to work plan

F. Communication

Upon receipt of my patient's signed medical authority, I would like the:

☐ Case Manager to contact me once they have received this certificate (where a claim exists)

☐ Employer to contact me once they have received this certificate (where a claim exists)

Preferred contact method: ☐ phone ☐ email ☐ fax ☐ writing ☐ visit

(refer to section G for contact details)

G. Doctor's details

Doctor's name:

Address:

Phone:

Provider Number:

Email address:

Fax:

Signed:

Completion date: