Form

Statement of fitness for work – Final certificate

Please complete all sections of this form

- *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:				
Workplace location where injury or disease occurred:						

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

3. Medical assessment					
Date of examination:		Time of examination:		AM ☐	PM ☐
Having examined the worker it is my opinion that as from:	Date:				
The worker has ceased to be incapacitated for work					☐
The workers incapacity is no longer a result of the work-related injury / disease					☐
The worker has fully recovered from the work related condition					☐
Grounds for the opinion of medical assessment:					☐

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