



Form 4A

WorkCover WA – PROGRESS certificate of capacity

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

4. PROGRESS REPORT

Activities/interventions	Actual outcome (<i>change in symptoms, function, activity and work participation</i>)	Still required?*	
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*(If management activities/interventions are still required, please also list them in Section 6 'Injury Management Plan')

☐ Other factors appear to be impacting recovery and return to work

Comment

5. 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 on next page)

5. WORK CAPACITY (CONTINUED)

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)

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

6. INJURY MANAGEMENT PLAN

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

- ☐ I support the RTW program established by the employer/insurer/WRP dated
- ☐ I would like more information about available duties ☐ I would like to be involved in developing the RTW program
- ☐ Please engage a workplace rehabilitation provider *(If you have made a referral, provide name and contact details below)*

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 - engage workplace rehabilitation provider, establish return to work program*

7. NEXT REVIEW DATE

- ☐ I will review worker again on *(If greater than 28 days, please provide clinical reasoning)*

Comments

8. 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)