Form

Statement of fitness for work – First certificate

This is the approved form for a first statement of fitness for work up to 14 days

Section 82(1)(b) of the *Return to Work Act* requires a claim for compensation be accompanied by a statement of fitness for work in a form approved by the Authority. This form is the approved form for use by a medical practitioner or another person of a class prescribed by regulation that certifies a worker's capacity for work.

- *Medical practitioner to retain a copy*
- *This statement to be given to worker*
- *Worker to give this statement to employer with a completed Northern Territory workers compensation claim form*

Worker details						
Surname:						
Given names:						
Date of birth:		Gender:	Male ☐ Female ☐		Occupation:	
Address:						
Suburb:				State:	Postcode:	
Home number:		Work number:				
Mobile number:		Email address:				

Employer details						
Employer name:						
Address:						
Suburb:				State:	Postcode:	
Work number:		Fax number:				
Mobile number:		Email address:				

Injury details (from worker)	
Date of injury or disease first noticed:	
Workplace location where injury or disease occurred:	
Workers description of the injury or disease:	
Workers description of how the injury or disease occurred:	

Medical assessment (tick only those boxes which apply)			
Date of examination:		Time of examination:	AM ☐ PM ☐
In my opinion the injury or disease is:	Consistent with the stated cause		☐
	Inconsistent with the stated cause		☐
	Of uncertain cause (please comment below)		☐
History of current condition:			
Examination:			
Investigations:			
Diagnosis:			
Complications:			

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)		☐
Is this a FIRST and FINAL statement of fitness for work?					Yes ☐	No ☐	

Injury management (tick only those boxes which apply)					
1. 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	
2. 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):					
Case conference recommended (specify):					☐
Vocational rehabilitation referral:	May be necessary ☐		May not be necessary ☐		
3. Review date	Worker to be reviewed on:				

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