

## 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

<b>1. Worker details</b>										
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:										
<b>2. Employer details</b>										
Employer name:										
Address:										
Suburb:					State:				Postcode:	
<b>3. Medical assessment</b>										
Date of examination:					Time of examination:				AM <input type="checkbox"/> PM <input type="checkbox"/>	
Having examined the worker it is my opinion that as from:		Date:								
The worker has ceased to be incapacitated for work									<input type="checkbox"/>	
The workers incapacity is no longer a result of the work-related injury / disease									<input type="checkbox"/>	
The worker has fully recovered from the work related condition									<input type="checkbox"/>	
Grounds for the opinion of medical assessment:									<input type="checkbox"/>	
<b>4. Medical practitioner details</b>										
Name:					Registration number:					
Address:					Suburb:					
State:				Postcode:				Work number:		
Fax number:					Email address:					
Signature:					Date:					