

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 <input type="checkbox"/>		Female <input type="checkbox"/>		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 <input type="checkbox"/>		PM <input type="checkbox"/>	
In my opinion the injury or disease is:		Consistent with the stated cause							<input type="checkbox"/>
		Inconsistent with the stated cause							<input type="checkbox"/>
		Of uncertain cause (please comment below)							<input type="checkbox"/>
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.									<input type="checkbox"/>		
Fit to return to pre-injury duties , but requires further treatment									<input type="checkbox"/>		
Fit to return to work for restricted hours / days from:									<input type="checkbox"/>		
		to	(inclusive)		hours per day		hours per week				
Fit to return to work on restricted duties from:					to		(inclusive)				
Restricted duties:	Avoid prolonged standing / walking / sitting								<input type="checkbox"/>		
	Avoid squatting / kneeling / ladders / steps								<input type="checkbox"/>		
	No lifting anything heavier than:		5kg	<input type="checkbox"/>	10kg	<input type="checkbox"/>	15kg	<input type="checkbox"/>	20kg	<input type="checkbox"/>	
	Avoid repetitive use of affected body part								<input type="checkbox"/>		
	Avoid repetitive bending / lifting								<input type="checkbox"/>		
	Other (please specify)								<input type="checkbox"/>		
Totally unfit for work from:					to		(inclusive)				
Is this a FIRST and FINAL statement of fitness for work?									Yes <input type="checkbox"/> No <input type="checkbox"/>		
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									<input type="checkbox"/>		
The worker will require more than three days off work, consequently I will be happy to discuss this further with the employer / insurer.									<input type="checkbox"/>		
Preferred contact days and time:		Monday	<input type="checkbox"/>	Tuesday	<input type="checkbox"/>	Wednesday	<input type="checkbox"/>	Thursday	<input type="checkbox"/>	Friday	<input type="checkbox"/>
		Saturday	<input type="checkbox"/>	Sunday	<input type="checkbox"/>	Times:	AM	OR	PM		
2. Medical management plan											
Treatment (specify):									<input type="checkbox"/>		
Medication (specify):									<input type="checkbox"/>		
Referred to specialist: (specialty/name):									<input type="checkbox"/>		
Date of appointment:		Time of appointment:		AM		<input type="checkbox"/>	PM	<input type="checkbox"/>			
Referred to hospital (specify):									<input type="checkbox"/>		
Referred to Allied Health Professional(s):											
Physiotherapist name:						Number of sessions recommended					
Chiropractor name:						Number of sessions recommended					
Other (specify):											
Case conference recommended (specify):									<input type="checkbox"/>		
Vocational rehabilitation referral:		May be necessary		<input type="checkbox"/>	May not be necessary		<input type="checkbox"/>				
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:					