WorkCover WA – FINAL certificate of capacity

FORM 4

1. WORKER'S DETAILS

First name | Last name

Date of birth | Claim no.

Phone | Email

Address

2. EMPLOYER'S DETAILS

Employer's name | Employer's phone

Employer's address

3. MEDICAL ASSESSMENT

Date of this assessment | Date of injury

☐ The worker's condition is unlikely to change substantially in the next 12 months

4. WORK CAPACITY

Having considered the health benefits of work, I find this worker to have:

☐ **full capacity for work** from ☐ but requires further treatment *(outline specifics below)*

☐ **capacity for work** performing ____ hours per day and ____ days per week from

as outlined below: *(Please outline the worker's physical and/or psychosocial capacity for work, functional limits, ongoing need for workplace modifications, and/or further treatment needs)*

☐ lift up to ____ kg

☐ sit up to ____ mins

☐ stand up to ____ mins

☐ walk up to ____ m

☐ work below shoulder height

☐ **The worker's incapacity is no longer a result of the injury**

5. REASON FOR CAPACITY/INCAPACITY

Please outline your clinical reason for the worker's capacity/incapacity:

6. MEDICAL PRACTITIONER'S DETAILS

Name | AHPRA no. MED

Address | Email

Signature

Phone

Fax | Date

(Practice stamp – optional)