



WorkCoverWA



Form 3

WorkCover WA – FIRST certificate of capacity

1. WORKER'S DETAILS

First name	<input type="text"/>	Last name	<input type="text"/>
Date of birth	<input type="text"/>	Email	<input type="text"/>
Phone	<input type="text"/>	Mobile	<input type="text"/>
Address	<input type="text"/>		

2. EMPLOYMENT DETAILS

Worker's job title	<input type="text"/>	Employer's name	<input type="text"/>
Employer's address	<input type="text"/>		

3. CONSENT AUTHORITY

I consent to any medical practitioner who treats me (whether named on this certificate or not) to discuss my medical condition with my employer, insurer and other medical or allied health professionals for the purpose of my claim for workers' compensation and return to work options.

Worker's signature	<input type="text"/>	Print name	<input type="text"/>
		Date	<input type="text"/>

4. WORKER'S DESCRIPTION OF INJURY

Date of injury	<input type="text"/>
What happened?	<input type="text"/>
Worker's symptoms	<input type="text"/>

5. MEDICAL ASSESSMENT

Date of this assessment	<input type="text"/>
Clinical findings	<input type="text"/> <input type="text"/>
Diagnosis	<input type="text"/>
The injury is consistent with worker's description of how injury occurred <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> uncertain	
The injury is: <input type="checkbox"/> a new condition <input type="checkbox"/> a recurrence of a pre-existing condition	

6. 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 below)

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

7. INJURY MANAGEMENT PLAN

Activities/interventions	Purpose/goal (likely change in symptoms, function, activity and work participation)
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

I would like: ☐ more information about available duties ☐ a RTW program to be established

☐ to be involved in developing the RTW program

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 - identify suitable duties, establish return to work program

8. NEXT REVIEW DATE

- ☐ Worker does not need to be reviewed again (FIRST and FINAL certificate of capacity)
- ☐ I will review worker again on (If greater than 14 days, please provide clinical reasoning)

Comments

9. 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"/>	Date	<input type="text"/>
Fax	<input type="text"/>		

(Practice stamp – optional)