Form 4A

WorkCover WA – PROGRESS certificate of capacity

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

Diagnosis

4. PROGRESS REPORT

Activities/interventions	Actual outcome *(change in symptoms, function, activity and work participation)*	Still required?*
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

**(If management activities/interventions are still required, please also list them in Section 6 'Injury Management Plan')*

☐ Other factors appear to be impacting recovery and return to work

Comment

5. 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 on next page)*

5. WORK CAPACITY (CONTINUED)

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)

- ☐ lift up to ____ kg
- ☐ sit up to ____ mins
- ☐ stand up to ____ mins
- ☐ walk up to ____ m
- ☐ work below shoulder height

6. INJURY MANAGEMENT PLAN

Activities/interventions	Purpose/goal *(likely change in symptoms, function, activity and work participation)*

☐ I support the RTW program established by the employer/insurer/WRP dated ____

☐ I would like more information about available duties ☐ I would like to be involved in developing the RTW program

☐ Please engage a workplace rehabilitation provider *(If you have made a referral, provide name and contact details below)*

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 - engage workplace rehabilitation provider, establish return to work program*

7. NEXT REVIEW DATE

☐ I will review worker again on ____ *(If greater than 28 days, please provide clinical reasoning)*

Comments

8. MEDICAL PRACTITIONER'S DETAILS

Name

Address

Phone

Fax

AHPRA no. MED

Email

Signature

Date

(Practice stamp – optional)