INITIAL CERTIFICATE SECTION BY SECTION

SECTION 1 – INITIAL MEDICAL CERTIFICATE COMPLETION

Under Section 34(1)(b) of the *Workers Rehabilitation and Compensation Act 1988* an initial medical certificate validates a new workers compensation claim. An initial certificate should ONLY be completed upon the worker's **FIRST** consultation and may also be used as a clearance certificate where the worker's injury is minor and no further intervention is required (refer to Section 8).

SECTIONS 2 & 3 are self explanatory.

SECTION 4 - MEDICAL ASSESSMENT

Please differentiate between *presenting symptoms* and an actual *medical diagnosis*.

SECTION 5 - STATED CAUSE

This is a statement of how the worker stated the condition arose. The medical practitioner should simply detail the facts as relayed to them by the worker. If there are other relevant factors relating to the worker's condition, such as past medical history, they should be outlined in the comments section. Comments on external influences on the worker's condition can also be included here; for example, sports, hobbies, social activities.

Recurrence

For a recurrence of an injury or disease to be compensable, the original injury or disease must have been accepted for compensation. A recurrence implies that there has been no new incident or contribution from the worker's employment, simply that the incapacity has again resulted from the compensable condition. The recurrence of an existing condition that has been accepted as a compensable condition can be subject of a claim for compensation whether the recurrence occurs within the workplace or externally to the workplace.

Aggravation

An aggravation implies that there has been a new incident or exposure, arising out of or in the course of the worker's employment, which has caused an increase in the gravity of the worker's condition. Aggravation can relate to any condition, whether initially work related or not, that is made worse through a work related incident or work situation.

SECTION 6 – WORKPLACE CONTACT

Workplace contact initiated by the medical practitioner is encouraged. Contact with an employer can greatly improve the worker's return to work outcome, primarily through the identification of available suitable duties that may have otherwise resulted in certification of total incapacity.

SECTION 7 – CAPACITY TO WORK

Where the worker is incapacitated for any work, that is, unable to do any work of any kind, certification should only be granted up to a maximum of 14 days. In circumstances where certification for more than 14 days is required, the medical practitioner must provide reasons to substantiate the decision, together with an appointed review date (Section 8).

Suitable Duties

Where the worker is assessed as partially incapacitated, legislation requires that the employer provides suitable duties.

Suitable duties may include:

- changes or restrictions to a worker's pre-injury duties to allow them to return to work and/or
- different duties from those performed by the worker prior to the injury or disease.

Restrictions

When a worker is deemed fit to return to suitable duties, restrictions assist to outline any limitations and/or accommodation issues that exist upon the worker's return to work. Restrictions safeguard the worker and ensure that planned return to work processes are appropriate and do not put the worker at risk of re-injury.

In circumstances where restrictions are more complex, it is advisable that the medical practitioner contacts the employer to provide a comprehensive explanation of the worker's functional capacity so that it is clearly understood.

Details of any permanent restrictions that may have resulted are also to be included.

SECTION 8 – MEDICAL MANAGEMENT

To assist in the management of the worker's injury, details concerning proposed treatment (including referral to other service providers) are to be supplied, including the name of the service provider as well as the type of service that is to be provided.

It is important that medical information is shared between treating providers, no matter what their level of involvement, to ensure they are fully aware of all the medical information important to the worker's medical management.

The last part of this section is completed to indicate when, or if, the worker's condition needs to be reviewed.

SECTION 9 – SIGNATURES

The worker is asked to give their consent for the medical practitioner to contact the employer and to the dissemination of information on the claim form. This allows the employer and the insurer to gather relevant information on the claim.

The certificate should carry the date that it is actually signed by the worker and the medical practitioner, even if the visit was on another day (that will be indicated by the date of examination in Section 4).

For the purpose of this form:

- reference to an '**accredited medical practitioner**' includes a '**medical practitioner**' as defined under the *Workers Rehabilitation and Compensation Act 1988;* and
- reference to a '**medical practitioner'** includes a **'primary treating medical practitioner'** as defined under the *Workers Rehabilitation and Compensation Act 1988.*

Please note:

Once all sections of the certificate have been completed, please ensure that the worker's copy is placed inside the envelope provided by WorkCover Tasmania.

Incomplete certificates can result in a worker's claim being rejected or deferred and consequently may cause considerable financial hardship to the worker due to delays in payment of benefits.

Purple – Insurer's copy
Brown – Worker's copy
Green – Doctor's copy

INITIAL
Workers Compensation Medical Certificate

Section 34(1)(b) of the Workers Rehabilitation and Compensation Act 1988

WorkCover TASMANIA

PLEASE PRINT

1. Initial Medical Certificate Completion

This form is to be completed for INITIAL consultations only
If it is NOT the patient's first consultation a CONTINUING/FINAL Workers Compensation Medical Certificate must be completed
All sections of this form must be completed unless stated otherwise

2. Worker's Name

3. Employer's Name

4. Medical Assessment

I examined the above worker on .....

Presenting Symptoms:

.....

.....

Diagnosis: ☐ **Provisional** ☐ **Final**

Details (do not restate symptoms):

.....

.....

5. Stated Cause

The abovenamed worker stated the condition to be caused by:

☐ an incident which occurred on .....

☐ a disease, symptoms of which became evident on .....

The worker stated that the injury or disease occurred under the following circumstances:

.....

.....

.....

The injury or disease is:

☐ consistent with the stated cause

☐ inconsistent with the stated cause Give reasons:

.....

.....

☐ of uncertain cause Give reasons:

.....

.....

If known, the injury or disease is: (Refer to explanatory notes on cover for definitions)

☐ a recurrence of a previously compensable condition

☐ an aggravation of an existing condition

☐ a new condition

Past history of similar injury or comments relevant to condition:

.....

.....

6. Workplace Contact

Has the workplace/employer been contacted to discuss management and/or restrictions?

☐ YES ☐ NO

Workplace Contact ..... Date .....

7. Capacity to Work

Prior to determining work capacity it is recommended that the worker's employer/workplace is contacted (refer previous)

Note: Capacity is determined by the medical practitioner's assessment not by the availability of work in the workplace

I consider the worker:

☐ Has not been incapacitated for work and is fit for pre-injury duties **(proceed to 9)**

☐ Requires treatment but is fit for pre-injury duties **(proceed to 8)**

☐ Is fit for suitable duties (Refer to explanatory notes on cover for definition)
from ..... to .....

Please indicate any restrictions that should apply: (eg: transport restrictions, restriction of hours, need for rest breaks, limb and mobility restrictions)

.....

.....

(proceed to 8)

☐ Will be incapacitated for **any** work from
..... to .....

If greater than 14 days give reasons together with an appointed review date at **Section 8**:

.....

.....

☐ Will cease to be incapacitated for work on ..... **(proceed to 9)**

8. Medical Management

Has the worker consulted any other health professionals regarding these symptoms?

☐ YES Details: .....
.....

☐ NO

Treatment/medication/investigations:

.....

.....

I have referred the worker to: (usual GP/other health professionals)

Name of provider:

Details:

I wish to review the worker

☐ YES On .....

☐ NO Injury is minor and no further intervention is required (first and final consultation)

9. Signatures

Worker's consent to contact and discuss matters in this certificate with employer, including any agent of the employer:

Signature: ..... Date .....

WorkCover Accredited Medical Practitioner

Signature: ..... Date .....

10. WorkCover Accredited Medical Practitioner Details

Name:

Address:

Phone: Fax:

GP/Specialty: Provider No:

Once all sections have been completed please ensure that the worker's copy is placed inside the envelope provided by WorkCover Tasmania