NSW GOVERNMENT | WorkCover

WorkCover NSW – certificate of capacity

Please ensure all sections are completed. Tick if this is the initial certificate for this claim ☑

PART A – MAY BE COMPLETED BY PATIENT

Patient's first name: othernames

Last name: surname

Date of birth (DD/MM/YYYY): 20/07/1971

Patient's address: street address, suburb, state postcode

Claim number: claimno

Medicare number:

Shaded areas to be completed for initial certificate only

Patient's occupation/job title: occupation

Employer's name and contact details: emp_name, emp_address, emp_suburb, emp_state emp_postcode

I consent to my treating medical practitioner, my employer, the insurer, other treating practitioners, workplace rehabilitation providers and WorkCover exchanging information for the purposes of managing my injury and workers compensation claim. I understand that this information will be used by WorkCover and insurers to fulfil their functions under the workers compensation legislation.

Signature of patient

Date (DD/MM/YYYY): 24/06/7777

PART B – TO BE COMPLETED BY NOMINATED TREATING DOCTOR OR TREATING SPECIALIST MEDICAL PRACTITIONER

MEDICAL CERTIFICATION

Diagnosis of work related injury/disease: diagnosis

Patient stated date of injury: 22/11/1010

Shaded areas to be completed for initial certificate only

Patient was first seen at this practice/hospital for this injury/disease on: 00/00/0000

Injury/disease is consistent with patient's description of cause ☑ Yes ☐ No ☐ Uncertain

How is the injury/disease related to work?

injury_desc

Detail any pre-existing factors which may be relevant to this condition

WORK SAFE HOME SAFE

Claimant name: othernames surname

Claim number: claimno

MANAGEMENT PLAN FOR THIS PERIOD

Treatment/medication type and duration (Duration: short term = < 6 weeks, medium term = 6–12 weeks, long term = > 12 weeks)

manag_plan

Referral to another health care provider (provide details of provider and service requested, duration and frequency when relevant)

CAPACITY FOR EMPLOYMENT (Please consider the health benefits of work when completing this section)

Do you require a copy of the position description/work duties? ☐ Yes ☑ No

Patient:

☐ is fit for pre-injury duties

☑ has capacity for some type of employment from 28/03/3333 to 27/04/4444

for ha hours/day ha days/week

☐ has no current work capacity for any employment from / / to / /

If no current work capacity, estimated time to return to any type of employment

Factors delaying recovery

Do you recommend referral to workplace rehabilitation provider? ☐ Yes ☑ No

Capacity – If the patient is fit for pre-injury duties this section does not need to be completed. For all other patients please consider activities of daily living currently being performed.

Lifting/carrying capacity	has_cap_for_liftingupto
Sitting tolerance	has_cap_for_sittingupto
Standing tolerance	has_cap_for_standingupto
Pushing/pulling ability	has_cap_for_walkingupto
Bending/twisting/squatting ability	has_cap_for_keyingupto
Driving ability	has_cap_for_travellingupto

Other (please specify) eg psychological considerations, keep wound clean and dry

n/a

Next review date 23/07/8888 (if greater than 28 days, please provide clinical reasoning)

Comments

TREATING MEDICAL PRACTITIONER DETAILS

☐ Please tick if you agree to be the nominated treating doctor for the ongoing management of this worker's injury and return to work.

I certify that I am the ☐ nominated treating doctor or ☑ treating specialist (please tick) and I have examined this patient. The information and medical opinions contained in this certificate of capacity are, to the best of my knowledge, true and correct.

Signature

Date (DD/MM/YYYY) 24/06/7777

Name (practice stamp if available)

doc_name - Chromis

Address

PO Box 19 Lorn NSW 2320

Telephone number 0249369999

Provider number provider

PART C – TO BE COMPLETED BY THE WORKER PRIOR TO SENDING TO THE EMPLOYER OR INSURER (this does not involve the nominated treating doctor/treating specialist)

WORKER DECLARATION

Worker's first name: othernames

Last name: surname

Date of birth (DD/MM/YYYY): 20/07/1971

Worker's address: street address, suburb, state postcode

Claim number: claimno

I ☐ have ☐ have not (tick appropriate box)

engaged in any form of paid employment, self employment or voluntary work for which I have received or am entitled to receive payment in money or otherwise since the last certificate was provided, that I have not yet declared to the insurer.

If you have been engaged in any form of paid employment or voluntary work, please provide details below (or attach when you forward this certificate to your employer or insurer).

I declare that the details I have given on this declaration are true and correct, knowing that false declarations are punishable by law.

Signature of worker

Date (DD/MM/YYYY) ☐☐/☐☐/☐☐☐☐

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