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

Last name

Date of birth (DD/MM/YYYY)

Patient's address

Claim number

Medicare number

Shaded areas to be completed for initial certificate only

Patient's occupation/job title

Employer's name and contact details

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)

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

MEDICAL CERTIFICATION

Diagnosis of work related injury/disease

Patient stated date of injury

Shaded areas to be completed for initial certificate only

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

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

How is the injury/disease related to work?

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

Claimant name | Claim number

MANAGEMENT PLAN FOR THIS PERIOD

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

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 ☐☐/☐☐/☐☐☐☐ to ☐☐/☐☐/☐☐☐☐

for ☐☐ hours/day ☐☐ 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

Sitting tolerance

Standing tolerance

Pushing/pulling ability

Bending/twisting/squatting ability

Driving ability

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

Next review date ☐☐/☐☐/☐☐☐☐ (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) ☐☐/☐☐/☐☐☐☐

CHROMIS

Name (practice stamp if available)

Address

Telephone number ☐☐☐☐☐☐☐☐☐☐

Provider number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

Last name

Date of birth (DD/MM/YYYY)

Worker's address

Claim number

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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