NSW GOVERNMENT | WorkCover

WorkCover NSW - certificate of capacity

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

PART A – MAY BE COMPLETED BY PATIENT

Patient's first name: Matthew

Last name: Walsh

Date of birth (DD/MM/YYYY): 14/3/1994

Telephone number: 0423-143-306

Patient's address: 16/21 View St, MIRANDA,NSW 2228

Claim number:

Medicare number: 2735 97647 2 / 1

Shaded areas to be completed for initial certificate only

Patient's occupation/job title: Mechanic

Employer's name and contact details: City Ford Rokdale

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: M Walsh

Date (DD/MM/YYYY): 1/08/2019

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

MEDICAL CERTIFICATE

Diagnosis of work related injury/disease: R Foot Injury

Patient stated date of injury: 31/07/2019

Shaded areas to be completed for initial certificate only

Patient was first seen at this practice/hospital for this injury/disease on: 01/08/2019

Injury/disease is consistent with patient's description of cause [x] Yes [ ] No [ ] Uncertain

How is the injury/disease related to work?

Car Gear Box - fell on boot - missed the steel cap. Now has pain, bruise, swelling in mid foot.

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

Nil known

Claimant name: Matthew Walsh

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)

NSAID ; Rest ; Ice ; Elevation

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

X-Ray

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 **01/08/2019** to **04/08/2019**

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 **05/08/2019** (if greater than 28 days, please provide clinical reasoning)

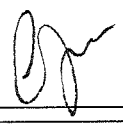
Comments

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 or [ ] other* 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) **1/08/2019**

* If 'other', please specify

Name (practice stamp if available)

Dr Charan Jeet Arora

Address

573 Kingsway, MIRANDA, NSW 2228

Telephone number: 9540 1044

Fax number: 9526 1343

Provider number: 4573142W

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: Matthew

Last name: Walsh

Date of birth (DD/MM/YYYY): 14/3/1994

Worker's address: 16/21 View St, MIRANDA, NSW 2228

Claim number:

I ☐ have ☐ have not (check 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: C J Walsh

Date (DD/MM/YYYY): **1/08/2019**

Catalogue No. **WC01300** WorkCover Publications Hotline **1300 799 003**
WorkCover NSW, 92-100 Donnison Street, Gosford, NSW 2250
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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: Matthew

Last name: Walsh

Date of birth (DD/MM/YYYY): 14/3/1994

Telephone number:

Patient's address: 16/21 View St, MIRANDA,NSW 2228

Claim number:

Medicare number: 2735 97647 2 / 1

Shaded areas to be completed for initial certificate only

Patient's occupation/job title: Mechanic

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: M Walsh

Date (DD/MM/YYYY): 05/08/2019

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

MEDICAL CERTIFICATE

Diagnosis of work related injury/disease: Right foot injury

Patient stated date of injury: 31/07/19

Shaded areas to be completed for initial certificate only

Patient was first seen at this practice/hospital for this injury/disease on: 01/08/2019

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

How is the injury/disease related to work?

Car Gear Box - fell on boot - missed the steel cap. Now has pain, bruise, swelling in mid foot.

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

no

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)

Rest, Ice, elevation, NSAIDs

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

X ray

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 05/08/2019 to 07/08/2019

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 07/08/2019 (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 or [ ] other* 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) 05/08/2019

* If 'other', please specify

Name (practice stamp if available)

Dr N. Lin

Address

573 Kingsway, MIRANDA, NSW 2228

Telephone number 029540 1044

Fax number 029526 1343

Provider number 5154521J

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: Matthew

Last name: Walsh

Date of birth (DD/MM/YYYY): 14/3/1994

Worker's address: 16/21 View St, MIRANDA, NSW 2228

Claim number:

I ☐ have ☐ have not (check 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: M J Walsh

Date (DD/MM/YYYY): 05/08/2019

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