## 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	N. Committee of the com
Patient's first name	Last name
Matthew	Walsh
Date of birth (DD/MM/YYYY)	Telephone number
14/3/1994	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	e insurer, other treating practitioners, workplace rehabilitation
providers and WorkCover exchanging information for the num	poses of managing my injury and workers compensation claim. I and insurers to fulfil their functions under the workers compensation
legislation.	IO modern of the first of the f
Signature of patient	Date (DD/MM/YYYY)
1711	1/08/2019
101 Wars	
	A STATE OF THE ATTIME OF COMMISSION MEDICAL PRACTITIONED
PART B TO BE COMPLETED BY NOMINATED TREATING D	OCTOR OR TREATING SPECIALIST MEDICAL PRACTITIONER
MEDICAL CERTIFICATE	
Diagnosis of work related injury/disease	
R Foot Injury	
Patient stated date of injury 31/07/2019	
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/di	isease on 01/08/2019
Injury/disease is consistent with patient's description of cause	
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	

WorkCover NSW – certificate of capacity Claim number Matthew Walsh Claimant name 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? No Yes Patient: is fit for pre-injury duties to has capacity for some type of employment from days/week for hours/day 04/08/2019 01/08/2019 has no current work capacity for any employment from 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 05/08/2019 (if greater than 28 days, please provide clinical reasoning) Next review date 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. Date (DD/MM/YYYY) Signature 1/08/2019 \* If 'other', please specify

Name		(practice stamp if available)	
Dr Charan Jeet Arora			
Address			
573 Kingsway, MIRANDA, NSV	V 2228		
Telephone number	Fax number	Provider number	
9540 1044	9526 1343	4573142W	

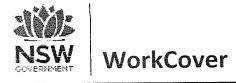
WorkCover NSW - certificate of capacity

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)

RKER DECLARATION	And Thomas in	
orker's first name	Last name	
atthew	Walsh	<u> </u>
te of birth (DD/MM/YYYY)		
1/3/1994		
orker's address		
3/21 View St, MIRANDA, NSW 2228		
im number		
have have not (check appropriate bo		
gaged in any form of paid employment, self employment or	voluntary work for which I have receiv	ed or am entitled to receive
yment in money or otherwise since the last certificate was		
rou have been engaged in any form of paid employment	or voluntary work, please provide de	tails below (or attach when you
ward this certificate to your employer or insurer).		
A Land Annual Land Company of the Annual Company of the Company of	was and correct knowing that false do	clarations are nunishable by law
declare that the details I have given on this declaration are t	Pate (DD/MM/YYYY)	ciarations are pullishable by law.
	LISTE (DD/MM/YYYY)	
ignature	1/08/2019	

Catalogue No. WC01300 WorkCover Publications Hotline 1300 799 003 WorkCover NSW, 92-100 Donnison Street, Gosford, NSW 2250 Locked Bag 2906, Lisarow, NSW 2252 | WorkCover Assistance Service 13 10 50 Website workcover.nsw.gov.au

ISBN 978 1 74341 191 9 © Copyright WorkCover NSW 1212



## WorkCover NSW - certificate of capacity

PART A - MAY BE COMPLETED BY PATIENT	the initial certificate for this claim
Patient's first name	Last name
Matthew	Walsh
Date of birth (DD/MM/YYYY)	Telephone number
14/3/1994	
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 certificat	e only
Patient's occupation/job title	
Mechanic	
Employer's name and contact details	
I consent to my treating medical practitioner, my emp	loyer, the insurer, other treating practitioners, workplace rehabilitation
providers and WorkCover exchanging information for	the purposes of managing my injury and workers compensation claim. I cover and insurers to fulfil their functions under the workers compensation  Date (DD/MM/YYYY)  05/08/2019
providers and WorkCover exchanging information for understand that this information will be used by Work legislation.  Signature of patient  PART B TO BE COMPLETED BY NOMINATED TREA	The purposes of managing my injury and workers compensation claim. It cover and insurers to fulfil their functions under the workers compensation  Date (DD/MM/YYYY)
providers and WorkCover exchanging information for understand that this information will be used by Work legislation.  Signature of patient  PART B TO BE COMPLETED BY NOMINATED TREA	Cathe purposes of managing my injury and workers compensation claim. It is cover and insurers to fulfil their functions under the workers compensation  Date (DD/MM/YYYY)  05/08/2019
providers and WorkCover exchanging information for understand that this information will be used by Work legislation.  Signature of patient  PART B TO BE COMPLETED BY NOMINATED TREAMEDICAL CERTIFICATE  Diagnosis of work related injury/disease	Cathe purposes of managing my injury and workers compensation claim. It is cover and insurers to fulfil their functions under the workers compensation  Date (DD/MM/YYYY)  05/08/2019
providers and WorkCover exchanging information for understand that this information will be used by Work legislation.  Signature of patient  PART B TO BE COMPLETED BY NOMINATED TREAMEDICAL CERTIFICATE	Cathe purposes of managing my injury and workers compensation claim. It is cover and insurers to fulfil their functions under the workers compensation  Date (DD/MM/YYYY)  05/08/2019
providers and WorkCover exchanging information for understand that this information will be used by Work legislation.  Signature of patient  PART B—TO BE COMPLETED BY NOMINATED TREAMEDICAL CERTIFICATE  Diagnosis of work related injury/disease	Cathe purposes of managing my injury and workers compensation claim. It is cover and insurers to fulfil their functions under the workers compensation  Date (DD/MM/YYYY)  05/08/2019
providers and WorkCover exchanging information for understand that this information will be used by Work legislation.  Signature of patient  PART B TO BE COMPLETED BY NOMINATED TREA  MEDICAL CERTIFICATE  Diagnosis of work related injury/disease  Right foot injury	The purposes of managing my injury and workers compensation claim. It cover and insurers to fulfil their functions under the workers compensation  Date (DD/MM/YYYY)  05/08/2019  ATING DOCTOR OR TREATING SPECIALIST MEDICAL PRACTITIONER  te only
providers and WorkCover exchanging information for understand that this information will be used by Work legislation.  Signature of patient  PART B TO BE COMPLETED BY NOMINATED TREA  MEDICAL CERTIFICATE  Diagnosis of work related injury/disease  Right foot injury  Patient stated date of injury  31/07/19	The purposes of managing my injury and workers compensation claim. It is cover and insurers to fulfil their functions under the workers compensation.  Date (DD/MWYYYYY)  05/08/2019  ATING DOCTOR OR TREATING SPECIALIST MEDICAL PRACTITIONER  te only
providers and WorkCover exchanging information for understand that this information will be used by Work legislation.  Signature of patient  PART B TO BE COMPLETED BY NOMINATED TREAMEDICAL CERTIFICATE  Diagnosis of work related injury/disease  Right foot injury  Patient stated date of injury  Shaded areas to be completed for initial certificates.	te only sinjury/disease on  O1/08/2019  O1/08/2019  O1/08/2019
providers and WorkCover exchanging information for understand that this information will be used by Work legislation.  Signature of patient  PART B TO BE COMPLETED BY NOMINATED TREA  MEDICAL CERTIFICATE  Diagnosis of work related injury/disease  Right foot injury  Patient stated date of injury  Shaded areas to be completed for initial certificate  Patient was first seen at this practice/hospital for this  Injury/disease is consistent with patient's description	te only sinjury/disease on of cause  Yes  No Uncertain
providers and WorkCover exchanging information for understand that this information will be used by Work legislation.  Signature of patient  PART B TO BE COMPLETED BY NOMINATED TREAMEDICAL CERTIFICATE  Diagnosis of work related injury/disease  Right foot injury  Patient stated date of injury  Shaded areas to be completed for initial certificate  Patient was first seen at this practice/hospital for this Injury/disease is consistent with patient's description How is the injury/disease related to work?	the purposes of managing my injury and workers compensation claim. It cover and insurers to fulfil their functions under the workers compensation  Date (DD/MM/YYYY)  05/08/2019  ATING DOCTOR OR TREATING SPECIALIST MEDICAL PRACTITIONER  te only sinjury/disease on  01/08/2019  of cause  Yes  No  Uncertain  Now has pain, bruise, swelling in mid foot.

WorkCover NSW - certificate of capacity Claim number Claimant name 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 07/08/2019 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? No Yes 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 Fax number Provider number 029540 1044 029526 1343 5154521J

WorkCover NSW - certificate of capacity

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			
Matthew	Walsh			
Date of birth (DD/MM/YYYY)				
14/3/1994				
Worker's address				
16/21 View St, MIRANDA, NSW 2228				
Claim number				
l 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 volu forward this certificate to your employer or insurer).	ıntary work, please provide details below (or attach when you			
•				
I declare that the details I have given on this declaration are true and	correct, knowing that false declarations are punishable by law.			
Signature	Date (DD/MM/YYYY)			
Mudsh	05/08/2019			
The state of the s				

Catalogue No. WC01300 WorkCover Publications Hotline 1300 799 003 WorkCover NSW, 92-100 Donnison Street, Gosford, NSW 2250 Locked Bag 2906, Lisarow, NSW 2252 | WorkCover Assistance Service 13 10 50 Website workcover.nsw.gov.au

ISBN 978 1 74341 191 9 © Copyright WorkCover NSW 1212