Certificate of capacity certificate of fitness

138-76-65

Prince of Wales Hospital



COOK, Mitchell John

certificate of fitness	27A Yarra Road F DOB: 12-Apr-2000	Phillip Bay 2036 1 19y Sex: M Ph: 0418320347 MC: 24164728684
For use with workers compensation and C	Compulsory ⁻	Third Party (CTP) motor
accident injury claims.		
CTP Workers compensation		
For CTP claims: 'Certificate of fitness' means 'certificate of fitness fo was employed at the time of the accident or not.	r work'. This certific	ate should be completed whether the person
Tick if this is the initial certificate for this claim.		
Section 1: To be completed by the injured	person or to	reating medical practitioner
First name	Last name	
MITCHELL	COOK	
Date of birth (DD/MM/YYYY) Telephone number	er	_
12/04/2000		
Address (must be residential address - not PO Box)		Suburb
27a YARRA ROAD		PHILLIP BAY
State Postcode Claim number		Medicare number
NSW 2036		2416 47286 8
Occupation/job title	Employer's nar	me and contact details (if applicable)
APPRENTICE MOTOR MECHANIC	CITY FO	ORO
I consent to my treating medical practitioner, my empl medical practitioners or health related practitioners (w rehabilitation providers and SIRA exchanging informat workers compensation/motor accident injury claim. I understand this information will be used by SIRA and accident insurance and workers compensation legislat Signature	vhether consulti ion for the purp I insurers to fulfi ion. Date (pp/mm/yyy	ng, treating or examining), workplace ose of managing my injury and Il their functions under the motor
Section 2: To be completed by treating m Medical certification	edical pract	itioner
Diagnosis of work related injury/disease or motor accident	dent related iniu	rv(ies)
acute low back pair	\ _	
Person's stated date of injury/accident (DD/MM/YYYY)	02/03/201	20
Shaded areas to be completed for initial certification was first seen at this practice/hospital for this injury on (DD/MM/YYYY) OWOSILO WO	Injury is consis of cause Yes	tent with person's description No Uncertain
Turning saddens felt my		ideal Low back poin
Detail any pre-existing factors which may be relevant t	to this condition	or injury(ies)

First name Last name	Claim number
Mitchell (OdC.	
Management plan for this period	
Treatment/medication type and duration	
To continue to wabilise	put No hour
To Carrier 10	
lutiting, or kendy to the	R +100/.
Referral to another health service or rehabilitation provide	
requested, duration and frequency when relevant)	
May benefit fre phys	70, and back reband
Capacity for activities – If the person has capacity for p	
completed. For all others please consider activities of daily	
	ting tolerance
Vio to luck.	Yes but limited to 1-hbs
	ushing/pulling ability
Yes, put inited	
	iving ability
V10.	Ye)
Other (please specify) eg psychological considerations, k	eep wound clean and dry
Next review date (DD/MM/YYYY) 9/03/2020	(if greater than 28 days, please provide clinical reasoning)
Comments	
Capacity for work (please consider the health benefits	of good work when completing this section).
Where the word 'capacity' appears below it should be rea	ad as 'fitness for work' when the certificate is
completed in a motor accident injury claim.	
Do you require a copy of the position description/work d	uties? Yes No
Date (DD/MM/YYYY)	
is fit for pre-injury work from	
type of work from	1/03/2000 for $4-8$ hours/day / days/week
E 1	
has no current capacity for any work from	
If no current capacity for work, estimated time to return	to any type of employment
Factors affecting recovery	
Byrend on relight, from	los book min

First name	Last name		Claim number
2777	3 1 13		
Treating medical practitioner			
I certify that I am the treating medi			
medical opinions contained in this c	certificate are, to t		ge, true and correct.
Signature		Date (DD/MM/YYYY)	
		02/03/2020	7
Name	1 0 0		
John VVIc	cleere		
Address	()11		
Vance of	J401	(10) MA()	
Suburb		∜ State	Postco de
hard 16	71	2013	1 nsu 1.
Telephone number		Provider number	1 . 50
releptione number		Provider Humber	
I agree to be the nominated tre			t of this person's injury,
treatment and recovery at/retu	'n to work (tick if	you consent).	
Section 3: Employment dec	laration (not to	be completed by the treating	ng medical practitioner)
This section is to be completed by t	he person prior to	sending to the insurer	(or employer).
First name		Last name	
MITCHELL		COOK.	
I have I have not (tick a	ppropriate box)		
engaged in any form of paid employ			
am entitled to receive payment in mot yet declared to the insurer.	oney or otherwise	e since the last certificat	e was provided, that I have
If so, please provide details below.			
il so, piease provide details below.			
		ÿ	
I doclare that the details I have given	on this doclaration	an are true and correct I	anough a that falso doctors.
I declare that the details I have giver are punishable by law.	i on this declaratio	ni are u ue and correct, l	diowing that laise declarations
Signature		Dato (DRAMASSA)	
Signature		Date (DD/MM/YYYY)	
		02/03/2020	
		ı	





Certificate of capacity/certificate of fitness



For use with workers compensation and Compulsory Third Party (CTP) motor accident injury claims. For CTP claims: 'Certificate of fitness' means 'certificate of fitness for work'. This certificate should be completed whether the person was employed at the time of the accident or not. Tick if this is the inital certificate for this claim Section 1: To be completed by the injured person or treating medical practitioner First name Last name Mitchell Cook Date of birth (DD/MM/YYYY) Telephone number 12/4/2000 96613574 Patient's address 27a Yarra Rd, PHILLIP BAY, NSW 2036 Claim number Medicare number 2416 47286 8 / 4 Occupation/job title Employer's name and contact details (if applicable) Injured person's consent Warauly 029331 5000 I consent to my treating medical practitioner, my employer (optional for CTP claims), the insurer, other medical practitioners or health related practitioners (whether consulting, treating or examining), workplace rehabilitation providers and SIRA exchanging information for the purpose of managing my injury and workers compensation/motor accident injury claim. I understand this information will be used by SIRA and insurers to fulfill their functions under the motor accident insurance and workers compensation legislation. Signature Date (DD/MM/YYY) 5/03/2020 Section 2: To be completed by treating medical practitioner Diagnosis of work related injury/disease or motor accident related injury(ies) Acute low back pain rt of centre some trcking of pain down th right leg Person's stated date of injury/accident (DD/MM/YYY) 02/03/2020 Shaded areas to be completed for initial certificate only Person was first seen at this practice/hospital for this injury on (DD/MM/YYY) 05/03/2020 Injury is consistent with pateint's description of cause Yes No Uncertain How is the injury related to work or the motor vehicle accident? twisting injury at work Detail any pre-existing factors which may be relevant to this condition or injury(ies) nil

First name	La	st name		Claim number
Management plan for this period				
Treatment/medication type and du	ration			
for analgesia & xry lumbar spir	ie			
Referral to another health service of frequency when relevant)	or rehabilitation prov	vider (include details c	of provider type and	d service requested, duration and
was quality whom tolevally				partition and advanced and
Capacity for activities – If the p all others please consider activities	erson has capacity	for pre-injury work thi	s section does not	need to be completed. For
Lifting/carrying capacity	The state of the s	nay being periorined		
Sitting tolerance				
Standing tolerance				
Pushing/pulling ability				
Bending/twisting/squatting ability				
Oriving ability				
•				
Other (please specify) eg psycholog	ical considerations,	, keep wound clean ar	nd dry	
Next review date 09/03/2020	1			
Comments	(If gre	eater than 28 days, pl	ease provide clinic	al reasoning)
pacity for work (please conside pacity' appears below it should be	r the health benef	fits of good work wh	en completing th	is section) Where the word
pacity' appears below it should b	e read as 'fitness	for work' when the	certificate is com	pleted in a motor accident
•				
o you require a copy of the position atient:	description/work du	uties? Yes	No	
is fit for pre-injury duties				
R				
has capacity for some type of wo	ork from			
for hours/day			to [
R Hours/day	days/wee	ek		
has no current work capacity for	anv employment fre	om 02/03/2020		
no current work capacity, estimated			to	09/03/2020
	and to return to an	y type of employment		
actors affecting recovery				

First name	Last name		Claim number
Treating medical practitioner deta I certify that I am the treating medical contained in this certificate are, to the Signature	practitioner and I have ex	rue and correct.	information andmedical opinions
	7 ~	Date (DD/MM/YYYY) 5/03/2020	
Name Dr. Achuthan .Gopinath Address Shop 131 Westfield Shopping Town,	152 Dunnerone Dood FAC	TOARDENO NOW 0000	
Telephone number 02 9344-7122	Fax number 02 9344-6649	Pro	vider number 23939F
at/return to work (tick if you cons Section 3: Employment declaration This section is to be completed by the pe	sent). I (not to be completed by th	e treating medical practitior	's injury, treatment and recovery
First name Mitchell I have engaged in any form of paid employme payment in money or otherwise since to the state of the s	ent, self employment or volu he last certificate was provi	intary work for which I have	propriate box) received or am entitled to receive lared to the insurer.
I declare that the details I have given o law.	n this declaration are true a	nd correct, knowing that fal	se declarations are punishable by
Signature		Date (DD/MM/YYYY) 5/03/2020	

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Certificate of capacity/ certificate of fitness



Tick if this is the inital certificate for	this claim
Section 1: To be some 1	
First name	d person or treating medical practitioner
Mitchell	Last name
Date of birth (DD/MM/YYYY)	Cook
12/4/2000	Telephone number
Patient's address	96613574
27a Yarra Rd, PHILLIP BAY,NSW 2036	
Claim number	
	Medicare number
Occupation/job title	2416 47286 8 / 4
	Employer's name and contact details (if applicable)
Injured person's consent	(ii applicable)
understand this information will be used by SIF vorkers compensation legislation.	ury and workers compensation/motor accident injury claim. RA and insurers to fulfill their functions under the motor accident insurance and
	ury and workers compensation/motors and SiRA exchanging
understand this information will be used by SIF workers compensation legislation. Signature	RA and insurers to fulfill their functions under the motor accident insurance and Date (DD/MM/YYY) 24/03/2020
understand this information will be used by SIF workers compensation legislation. Signature Section 2: To be completed by treating m	RA and insurers to fulfill their functions under the motor accident insurance and Date (DD/MM/YYY) 24/03/2020
understand this information will be used by SIF workers compensation legislation. Signature Section 2: To be completed by treating managements.	AA and insurers to fulfill their functions under the motor accident insurance and Date (DD/MM/YYY) 24/03/2020 Description of the motor accident insurance and the
understand this information will be used by SIF workers compensation legislation. Signature Section 2: To be completed by treating managements.	AA and insurers to fulfill their functions under the motor accident insurance and Date (DD/MM/YYY) 24/03/2020 Description of the motor accident insurance and the
understand this information will be used by SIF workers compensation legislation. Signature Section 2: To be completed by treating management of the completed by the completed by treating management of the completed by	T accident related injury(ies)
understand this information will be used by SIF workers compensation legislation. Signature Section 2: To be completed by treating management of the section in the section in the section is a section in the section	TAX and insurers to fulfill their functions under the motor accident insurance and Date (DD/MM/YYY) 24/03/2020 Dedical practitioner r accident related injury(ies)
understand this information will be used by SIF workers compensation legislation. Signature Section 2: To be completed by treating management of the section in the section in the section is section in the section i	Pate (DD/MM/YYY) [24/03/2020
understand this information will be used by SIF workers compensation legislation. Signature Section 2: To be completed by treating management of the section in the section in the section is a section in the section	Taccident related injury(ies) And workers compensation/motor accident injury claim. RA and insurers to fulfill their functions under the motor accident insurance and Date (DD/MM/YYY) 24/03/2020 Dedical practitioner Taccident related injury(ies)
understand this information will be used by SIF workers compensation legislation. Signature Section 2: To be completed by treating management of the section in the section in the section is a section in the section	Date (DD/MM/YYY) 24/03/2020 nedical practitioner r accident related injury(ies) YYY) cate only this injury on (DD/MM/YYY)
understand this information will be used by SIF workers compensation legislation. Signature Section 2: To be completed by treating maledical certification iagnosis of work related injury/disease or motor erson's stated date of injury/accident (DD/MM/V) maded areas to be completed for initial certification was first seen at this practice/hospital for the complete to the complete that is consistent with pateint's description of calcular transports.	Taccident related injury(ies) Cate only This injury on (DD/MM/YYY) Taccident injury on (DD/MM/YYY) Taccident injury on inj
understand this information will be used by SIF workers compensation legislation. Signature Section 2: To be completed by treating maledical certification iagnosis of work related injury/disease or motor erson's stated date of injury/accident (DD/MM/V) maded areas to be completed for initial certification was first seen at this practice/hospital for the complete to the complete that is consistent with pateint's description of calcular transports.	Taccident related injury(ies) Cate only This injury on (DD/MM/YYY) Taccident injury on (DD/MM/YYY) Taccident injury claim. Powders and SIRA exchanging and SIRA e
understand this information will be used by SIF workers compensation legislation. Signature Section 2: To be completed by treating management of the section in the section in the section is a section in the section	Taccident related injury(ies) Cate only This injury on (DD/MM/YYY) Taccident injury on (DD/MM/YYY) Taccident injury claim. Powders and SIRA exchanging and SIRA e
understand this information will be used by SIF workers compensation legislation. Signature Section 2: To be completed by treating maledical certification iagnosis of work related injury/disease or motor erson's stated date of injury/accident (DD/MM/N) added areas to be completed for initial certification in the completed for initial certification in the completed for initial certification in the completed for initial certification was first seen at this practice/hospital for the complete in the complete initial certification in the complete initial cer	Date (DD/MM/YYY) 24/03/2020 nedical practitioner r accident related injury(ies) YYY) icate only this injury on (DD/MM/YYY) we Yes No Uncertain cle accident?

Management plan for this pe		Claim number
manuagement plan for this na	Priod	
Treatment/medication type and	dunce-	
pain is easing off	duration	
to try restricted duties		
Referral to another health service	e or rehabilitation provide (
refd to Banchmark DT		tails of provider type and service requested, duration
refd to Benchmark PT eastga	rden Med Centre	
Capacity for activities - If the	2 narcon has a series	
all others please consider activities	e person has capacity for pre-injury wor es of daily living currently being perforr	rk this section does not need to be completed. For med
Lifting/carrying capacity	5 kjg	ned
Sitting tolerance	no restriction	
Standing tolerance	no restriction	
Pushing/pulling ability		
Bending/twisting/squatting ability	5 kg	
-	nil	8
Driving ability	no restriction	
Other (please specify) eg psycholo	ogical considerations, keep wound clea	an and dry
Next review date 07/04/2020	(if greater than as i	s, please provide clinical reasoning)
		provide diffical reasoning)
		provide difficult reasoning)
		provide difficult reasoning)
pacity for work (please considerably appears below it also	er the health benefits of good work	
Pacity for work (please conside acity' appears below it should by claim.	er the health benefits of good work be read as 'fitness for work' when the	
•		
you require a copy of the position		when completing this section).Where the word ne certificate is completed in a motor accident
you require a copy of the position		when completing this section).Where the word ne certificate is completed in a motor accident
you require a copy of the position tient: ss fit for pre-injury duties		when completing this section).Where the word ne certificate is completed in a motor accident
you require a copy of the position tient: is fit for pre-injury duties	description/work duties? Yes	when completing this section). Where the word ne certificate is completed in a motor accident
you require a copy of the position tient: is fit for pre-injury duties has capacity for some type of wo	description/work duties? Yes	when completing this section). Where the word ne certificate is completed in a motor accident
you require a copy of the position tient: is fit for pre-injury duties has capacity for some type of wo	description/work duties? Yes	when completing this section). Where the word ne certificate is completed in a motor accident
you require a copy of the position tient: is fit for pre-injury duties has capacity for some type of wo	description/work duties? Yes ork from 25/03/2020 5 days/week	when completing this section). Where the word ne certificate is completed in a motor accident
you require a copy of the position tient: is fit for pre-injury duties has capacity for some type of wo for 4 hours/day has no current work capacity for	description/work duties? Ork from 25/03/2020 5 days/week any employment from	when completing this section). Where the word ne certificate is completed in a motor accident s No
you require a copy of the position tient: is fit for pre-injury duties has capacity for some type of wo for 4 hours/day has no current work capacity for	description/work duties? Yes ork from 25/03/2020 5 days/week	when completing this section). Where the word ne certificate is completed in a motor accident s No
you require a copy of the position tient: is fit for pre-injury duties has capacity for some type of wo for 4 hours/day has no current work capacity for	description/work duties? Ork from 25/03/2020 5 days/week any employment from	when completing this section). Where the word ne certificate is completed in a motor accident s No



First name	Last name	CI-i-
		Claim number
Treating medical practitioner		
	r details edical practitioner and I have exam to the best of my knowledge, true	nined this person. The information andmedical op and correct.
		Date (DD/MM/YYYY)
0		24/03/2020
Name		
Dr. Achuthan .Gopinath		
Address		
Shop 131 Westfield Shopping To	own, 152 Bunnerong Road, EASTGA	
Telephone number	mi, 162 Bullifelong Road, EASTGA	RDENS, NSW 2036
02 9344-7122		Provider number
	02 9344-6649	0323939F agement of this person's injury, treatment and recover
ction 3: Employment declarat	tion (not to be completed by the trea	ting medical practitioners
s section is to be completed by the	Doroon = 1	S and practitioner)
1 -10 - 0) 1110	person prior to sending to the insure	er (or employer)
First name	person prior to sending to the insure	er (or employer)
irst name Mitchell	person prior to sending to the insure	er (or employer) name
First name Mitchell I have ngaged in any form of paid employ ayment in money or otherwise sinc	Last r	er (or employer) name
First name Mitchell I have I have I have of paid employ ayment in money or otherwise since so, please provide details below.	Last r Cook /ment, self employment or voluntary v ce the last certificate was provided, th	er (or employer) name c ave not (tick appropriate box) work for which I have received or am entitled to receive at I have not yet declared to the insurer.
First name Mitchell I have I have I have of paid employ ayment in money or otherwise since so, please provide details below.	Last r Cook /ment, self employment or voluntary v ce the last certificate was provided, the	er (or employer) name c ave not (tick appropriate box) work for which I have received or am entitled to receive at I have not yet declared to the insurer.
First name Mitchell I have ngaged in any form of paid employ ayment in money or otherwise since so, please provide details below.	Last r Cook /ment, self employment or voluntary v ce the last certificate was provided, the	er (or employer) name c ave not (tick appropriate box) work for which I have received or am entitled to receive at I have not yet declared to the insurer.

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Certificate of capacity/ certificate of fitness



tion 1: To be completed by the injured perso	on or treating medical practitioner
irst name	Last name
Mitchell	Cook
ate of birth (DD/MM/YYYY)	Telephone number
12/4/2000	96613574
atient's address	
27a Yarra Rd, PHILLIP BAY,NSW 2036	
Claim number	Medicare number
	2416 47286 8 / 4
Occupation/job title	Employer's name and contact details (if applicable)
Signature	Date (DD/MM/YYY) 24/03/2020
Section 2: To be completed by treating medic Medical certification Diagnosis of work related injury/disease or motor acc Person's stated date of injury/accident (DD/MM/YYY)	cident related injury(ies)
Shaded areas to be completed for initial certificat	
Person was first seen at this practice/hospital for this	
	Yes No Uncertain
njury is consistent with pateint's description of cause	
	accident?
njury is consistent with pateint's description of cause	accident?

First name		Last name		Claim number
			2	
Management plan for this porior				
Management plan for this period				
Treatment/medication type and dura	ation			
Referral to another health service or	r rehabilitation	provider (inclu	de details of provider type a	and service requested, duration and
frequency when relevant)				
Capacity for activities - If the pe	erson has capa	acity for pre-inj	ury work this section does r	not need to be completed. For
all others please consider activities	of daily living o	currently being	performed	
Lifting/carrying capacity				
Sitting tolerance			5- %	
Standing tolerance				
Pushing/pulling ability				
Bending/twisting/squatting ability	L			
Driving ability				
Other (please specify) eg psycholog	ical considera	tions, keep wo	und clean and dry	
Next review date 24/3	126	(if greater than	n 28 days, please provide c	linical reasoning)
Comments				
Capacity for work (please consid				
'capacity' appears below it should injury claim.	be read as 'fi	tness for wor	k' when the certificate is o	completed in a motor accident
Do you require a copy of the position	n description/v	vork duties?	Yes No	
Patient:				
is fit for pre-injury duties OR				
	unde fram		1	
has capacity for some type of v				0
for hours/day	da	ays/week		
OR			10/02/2020	24/02/2020
x has no current work capacity for		L-	10/03/2029	to 24/03/2020
If no current work capacity, estimate	ea time to retur	n to any type o	or employment	1
Factors affecting recovery				1

First name	Last name		Claim number
not traine			
Treating medical practitioner details I certify that I am the treating medical practi	tioner and I have ex	amined this person. The	e information andmedical opinions
contained in this certificate are, to the best	of my knowledge, tr	ue and correct.	
Signature		Date (DD/MM/YYYY)	
		24/03/2020	
~	^		
]	
Name			
Dr. Achuthan .Gopinath			
Address			
Shop 131 Westfield Shopping Town, 152 B	unnerong Road, EAS		
Telephone number	Fax number		rovider number 0323939F
02 9344-7122	02 9344-6649		J323939F
I agree to be the nominated treating d at/return to work (tick if you consent). Section 3: Employment declaration (not	to be completed by the	ne treating medical practit	
This section is to be completed by the person p	orior to sending to the	insurer (or employer)	
First name		Last name	
Mitchell		Cook	
I have engaged in any form of paid employment, so payment in money or otherwise since the last	elf employment or vol st certificate was prov	untary work for which I ha	appropriate box) eve received or am entitled to receive leclared to the insurer.
If so, please provide details below.			
14			
I declare that the details I have given on the law.	s declaration are true	e and correct, knowing tha	at false declarations are punishable by
Signature		Date (DD/MM/YY	YY)
rele		24/03/2020	

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