

# Certificate of capacity / certificate of fitness



State Insurance  
Regulatory Authority

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 initial certificate for this claim

## Section 1: To be completed by the injured person or treating medical practitioner

First name: Clint		Last name: Mcanally	
Date of birth: 28/07/1996		Telephone number: 0433 183 303	
Residential address (not PO Box): 31 Cogra Road 2256 NSW		Suburb: Woywoy	
State: NSW	Postcode: 2256	Claim No:	Medicare No: 2741118462 1 10/2022
Occupation/job title: Mechanic		Employer's name and contact details (if applicable):	

### Injured person's consent

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 fulfil their functions under the motor accident insurance and workers compensation legislation.

Signature: *C. Mcanally* Date: *29/8/2019*

## Section 2: To be completed by treating medical practitioner

### Medical certification

Diagnosis of work related injury/disease or motor accident related injury(ies):

Person's stated date of injury/accident: Date:

### Shaded areas to be completed for initial certificate only

Person was first seen at this practice/hospital for this injury on: Date:

Injury is consistent with person's description of cause: Yes

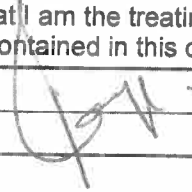
How is the injury related to work or the motor vehicle accident?

Detail any pre-existing factors which may be relevant to this condition or injury(ies):

First name:	Last name:	Claim Number:
Clint	Mcanally	

### Management plan for this period.

Treatment and duration: rest from work	Medication type and duration:
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continue physiotherapy seeing specialist next wk Having MRI scan as per specialist advice			
Referral to another health service or rehabilitation provider (include details of provider type and service requested, duration and frequency when relevant);			
spinal surgeon			
Capacity for activities - If the person has capacity for pre-injury work this section does not need to be completed. For all others 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):		Date: 12/09/2019	
Comments:			
Capacity for work (please consider the health benefits of good work when completing this section).			
Where the word 'capacity' appears it should be read 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 duties?			No
<input type="checkbox"/>	is fit for pre-injury work		
OR			
<input type="checkbox"/>	has capacity for some type of work from to for hours/day days/week		
OR			
✖	Has no current capacity for any work from	29/08/2019	to 12/09/2019
If no current capacity for work, estimated time to return to any type of employment:			
Factors affecting recovery:			
nil			
First name:	Last name:	Claim number:	
Clint	Mcanally		
Treating medical practitioner details			
I certify that I am the treating medical practitioner and I have examined this person, The information and medical opinions contained in this certificate are, to the best of my knowledge, true and correct.			
Signature:		Date:	
		29/8/2019	
Name:			
Dr Rokeya Fakir			

Address:		
Shop 17 12-14 Withers Road		
Suburb:	State:	Postcode:
Kellyville	NSW	2155
Telephone number:	Provider number:	
0282137455	412809TA	
<input checked="" type="checkbox"/>	I agree to be the nominated treating doctor for the ongoing management of this person's injury, treatment and recovery at/return to work (select if you consent)	

### Section 3: Employment declaration (not to be completed by the treating medical practitioner)

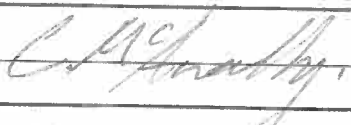
This section is to be completed by the person prior to sending to the insurer (or employer)

First name:	Last name:
<input type="checkbox"/> I have	<input type="checkbox"/> I have not (select 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 so, please provide details below.

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: 29/8/2019
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