Certificate of capacity certificate of fitness

2/3/20

138-76-65 Prince of Wales Hospital

COOK, Mitchell John

27A Yarra Road Phillip Bay 2036 ty

DOB: 12-Apr-2000 19y Sex: M Ph: 0418320347 MC: 24164728684

2/3/20

For use with workers compensation and Compulsory Third Party (CTP) motor accident injury claims.

☐ CTP ☑ Workers compensation

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: MITCHELL

Last name: COOK

Date of birth (DD/MM/YYYY): 12/04/2000

Telephone number:

Address (must be residential address – not PO Box): 27a YARRA ROAD

Suburb: PHILLIP BAY

State: NSW

Postcode: 2036

Claim number:

Medicare number: 2416 47286 8

Occupation/job title: APPRENTICE MOTOR MECHANIC

Employer's name and contact details (if applicable): CITY FORD

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

Signature:

Date (DD/MM/YYYY): 02/03/2020

Section 2: To be completed by treating medical practitioner

Medical certification

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

Acute low back pain.

Person's stated date of injury/accident (DD/MM/YYYY): 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/YYYY): 02/03/2020

Injury is consistent with person's description of cause: ☑ Yes ☐ No ☐ Uncertain

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

Turning suddenly felt immediate (R) sided low back pain.

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

NA.

First name: Mitchell | Last name: Cook. | Claim number:

Management plan for this period

Treatment/medication type and duration

To continue to mobilise but no heavy lifting, or bending to the floor.

Referral to another health service or rehabilitation provider (include details of provider type and service requested, duration and frequency when relevant)

May benefit from physio, and back rehab

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: No for 1 week.

Sitting tolerance: Yes but limited to 1-2 hrs

Standing tolerance: Yes, but limited

Pushing/pulling ability: No.

Bending/twisting/squatting ability: No.

Driving ability: Yes

Other (please specify) eg psychological considerations, keep 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 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? ☐ Yes ☐ No

	Date (DD/MM/YYYY)					
☐ is fit for pre-injury work from						
☐ has capacity for some type of work from	02/03/2020	to 09/03/2020	for 4-8	hours/day	1	days/week
☐ has no current capacity for any work from		to				

If no current capacity for work, estimated time to return to any type of employment

Factors affecting recovery

Depend on rehab, from low back injury

First name | Last name | Claim number

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 (DD/MM/YYYY) 02/03/2020

Name: John Mackenzie.

Address: Prince of Wales Hospital

Suburb: Randwick | State: NSW 2031 | Postcode:

Telephone number | Provider number

☐ I agree to be the nominated treating doctor for the ongoing management of this person's injury, treatment and recovery at/return to work (tick 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: MITCHELL | Last name: Cook.

☐ I have ☑ I 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 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 (DD/MM/YYYY) 02/03/2020

Catalogue No. SIRA08719
State Insurance Regulatory Authority, 92-100 Donnison Street, Gosford, NSW 2250
Locked Bag 2906, Lisarow, NSW 2252 | Customer Experience 13 10 50
Website www.sira.nsw.gov.au

NSW GOVERNMENT | State Insurance Regulatory Authority

Certificate of capacity/ certificate of fitness

NSW GOVERNMENT | 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 inital certificate for this claim**

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

First name: Mitchell

Last name: Cook

Date of birth (DD/MM/YYYY): 12/4/2000

Telephone number: 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): City Food, Alexandria Michael Macauley 02 9331 5000

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

Signature: meg

Date (DD/MM/YYY): 5/03/2020

Section 2: To be completed by treating medical practitioner

Medical certification

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 | Last name | Claim number

Management plan for this period

Treatment/medication type and duration

for analgesia & xry lumbar spine

Referral to another health service or rehabilitation provider (include details of provider type and service requested, duration and frequency when relevant)

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 09/03/2020 (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 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? ☐ Yes ☐ No

Patient:

☐ is fit for pre-injury duties

OR

☐ has capacity for some type of work from _____ to _____

for _____ hours/day _____ days/week

OR

☒ has no current work capacity for any employment from 02/03/2020 to 09/03/2020

If no current work capacity, estimated time to return to any type of employment

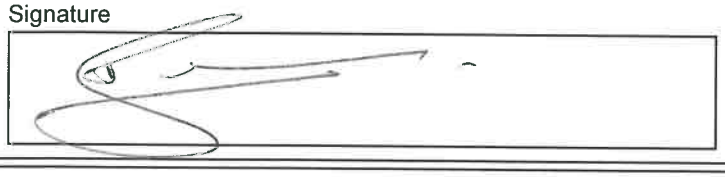
Factors affecting recovery

First name | Last name | Claim number

Treating medical practitioner details

I certify that I am the treating medical practitioner and I have examined this person. The information andmedical opinions contained in this certificate are, to the best of my knowledge, true and correct.

Signature



Date (DD/MM/YYYY) 5/03/2020

Name: Dr. Achuthan .Gopinath

Address: Shop 131 Westfield Shopping Town, 152 Bunnerong Road, EASTGARDENS, NSW 2036

Telephone number: 02 9344-7122 | Fax number: 02 9344-6649 | Provider number: 0323939F

☐ I agree to be the nominated treating doctor for the ongoing management of this person's injury, treatment and recovery at/return to work (tick 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: Mitchell | Last name: Cook

☐ I have ☐ I 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 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 (DD/MM/YYYY) 5/03/2020

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Certificate of capacity/ certificate of fitness

NSW GOVERNMENT | 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 inital certificate for this claim**

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

First name: Mitchell

Last name: Cook

Date of birth (DD/MM/YYYY): 12/4/2000

Telephone number: 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

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): 24/03/2020

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 (DD/MM/YYY)

Shaded areas to be completed for initial certificate only

Person was first seen at this practice/hospital for this injury on (DD/MM/YYY)

Injury is consistent with pateint's description of cause ☐ Yes ☐ No ☐ Uncertain

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

Management plan for this period

Treatment/medication type and duration

pain is easing off
to try restricted duties

Referral to another health service or rehabilitation provider (include details of provider type and service requested, duration and frequency when relevant)

refd to Benchmark PT eastgarden Med Centre

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	5 kjg
Sitting tolerance	no restriction
Standing tolerance	no restriction
Pushing/pulling ability	5 kg
Bending/twisting/squatting ability	nil
Driving ability	no restriction

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

Next review date 07/04/2020 (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 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? ☐ Yes ☐ No

Patient:

☐ is fit for pre-injury duties

OR

☐ has capacity for some type of work from 25/03/2020 to 08/04/2020

for 4 hours/day 5 days/week

OR

☐ 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 affecting recovery

First name

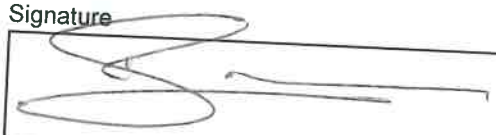
Last name

Claim number

Treating medical practitioner details

I certify that I am the treating medical practitioner and I have examined this person. The information andmedical opinions contained in this certificate are, to the best of my knowledge, true and correct.

Signature



Date (DD/MM/YYYY)

24/03/2020

Name

Dr. Achuthan .Gopinath

Address

Shop 131 Westfield Shopping Town, 152 Bunnerong Road, EASTGARDENS, NSW 2036

Telephone number

02 9344-7122

Fax number

02 9344-6649

Provider number

0323939F

☐ I agree to be the nominated treating doctor for the ongoing management of this person's injury, treatment and recovery at/return to work (tick 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

Mitchell

Last name

Cook

☐ I have ☐ I 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 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 (DD/MM/YYYY)

24/03/2020

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☐ **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: Mitchell

Last name: Cook

Date of birth (DD/MM/YYYY): 12/4/2000

Telephone number: 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

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): 24/03/2020

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 (DD/MM/YYY):

Shaded areas to be completed for initial certificate only

Person was first seen at this practice/hospital for this injury on (DD/MM/YYY):

Injury is consistent with pateint's description of cause ☐ Yes ☐ No ☐ Uncertain

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

Management plan for this period

Treatment/medication type and duration

Referral to another health service or rehabilitation provider (include details of provider type and service requested, duration and frequency when relevant)

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 24/3/20 (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 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? ☐ Yes ☐ No

Patient:

☐ is fit for pre-injury duties

OR

☐ has capacity for some type of work from ____ to ____

for ____ hours/day ____ days/week

OR

☒ has no current work capacity for any employment from 10/03/2029 to 24/03/2020

If no current work capacity, estimated time to return to any type of employment

Factors affecting recovery

First name | Last name | Claim number

Treating medical practitioner details

I certify that I am the treating medical practitioner and I have examined this person. The information andmedical opinions contained in this certificate are, to the best of my knowledge, true and correct.

Signature

Date (DD/MM/YYYY) 24/03/2020

Name: Dr. Achuthan .Gopinath

Address: Shop 131 Westfield Shopping Town, 152 Bunnerong Road, EASTGARDENS, NSW 2036

Telephone number: 02 9344-7122

Fax number: 02 9344-6649

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First name: Mitchell

Last name: Cook

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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 (DD/MM/YYYY) 24/03/2020

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Website www.sira.nsw.gov.au