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

Last name

Date of birth (DD/MM/YYYY)

Patient's address

Claim number

Medicare number

Shaded areas to be completed for initial certificate only

Patient's occupation/job title

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

Date (DD/MM/YYYY)

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

MEDICAL CERTIFICATION

Diagnosis of work related injury/disease

Patient stated date of injury

Shaded areas to be completed for initial certificate only

Patient was first seen at this practice/hospital for this injury/disease on

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

How is the injury/disease related to work?

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

WORK SAFE HOME SAFE