Australian Government
Department of Human Services

centrelink

Medical Certificate

Patient's details

Office use only — CRN

Family name

First name

Second name

Date of birth / /

Home address

Postcode

This person has been: My patient since / /

A patient of this practice since / /

Primary condition **Secondary/Related condition(s)**

Diagnosis — Please list the main medical conditions which impact on the patient's capacity to work or study (Primary condition should be the condition with the **most** impact).

Date of onset (if known) / /

Is this condition – Tick *ONE* only

Temporary ☐ Permanent (likely to persist for 2 years or more) ☐ Temporary exacerbation of a permanent condition ☐

Date of onset (if known) / /

Is this condition – Tick *ONE* only

Temporary ☐ Permanent (likely to persist for 2 years or more) ☐ Temporary exacerbation of a permanent condition ☐

Prognosis — Please estimate how long the symptom(s) will affect the patient's capacity to work or study.

Less than 3 months ☐ 3–12 months ☐ 13–24 months ☐ More than 24 months ☐ Uncertain ☐

Less than 3 months ☐ 3–12 months ☐ 13–24 months ☐ More than 24 months ☐ Uncertain ☐

Symptoms — Please list current symptoms for each condition.

Treatment — Please describe the patient's treatment regime, including past, current and planned treatment.

Past:

Current:

Planned:

Past:

Current:

Planned:

Please give details of any other medical conditions which impact on the patient's capacity to work or study.

Capacity to work or study

In my opinion the patient is/has been unfit for work/study

from / / to / /

Can the patient currently undertake their usual work or study?

Yes ☐ No ☐

Can the patient do any other work for 8 hours or more per week?

Yes ☐ No ☐

In order to prepare your patient for return to work or study, certain assistance may be offered. Please identify any factors which may impact on participation.

Certification by Medical Practitioner

Doctor's name (printed)

Qualifications Provider no.

Surgery/Medical Centre/ Hospital name

Address

Postcode

Phone number ( )

Signature

Date / /

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