

# CERTIFICATE OF CAPACITY



- A valid Certificate of Capacity must be provided if you are claiming compensation for loss of income because of a transport accident or work-related injury or illness.
- The certifier will use this Certificate of Capacity to communicate with your employer and your case manager about your work capacity (refer to the TAC or WorkSafe Victoria (WorkSafe) website for who can certify). Note: The first medical certificate for a work-related injury/condition WorkSafe claim must be issued by a medical practitioner.
- Certifiers - Please type or use block letters and ensure that all relevant sections are complete. Incomplete forms may be returned.

This certificate has been issued in relation to a:

Transport accident related injury (TAC Claim)  Work related injury/condition (WorkSafe Claim)

This certificate has been issued to confirm attendance only Complete sections 1, 2, 5 & 6 only

## 1. Worker Details

Worker First Name

ANDRES

Claim Number (if known)

08240066969

Worker Last Name

GUTIEREZ

Date of Injury (if Claim number not known)

18/03/2025

Worker Address

25B SUN CRESCENT

Date of Birth

07/07/1996

SUNSHINE VICTORIA

Postcode 3020

## 2. Diagnosis

I examined you on 13/11/2025

If this certificate refers to a period prior to the date of examination, please provide details in Additional Comments (Section 3) below

My Clinical Diagnosis/es based on my examination of you and other available information is:

R) 3rd & 4th Digit Trigger Finger

## 3. Capacity Assessment

Note: If capacity is affected further details MUST be provided in this section.

• Continue to Section 4 if capacity is unaffected

Your work capacity is affected by your injury/condition as follows:

Physical Function Select applicable	CAN	WITH MODIFICATIONS	CANNOT
Sit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand/Walk	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use injured arm/hand	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Lift	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck movement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Physical Function - Additional Comments eg. limits on durations, weight-handling capacity, repetitive or sustained postures, movements or forces:

Reduce repetitive use of right hand

Mental Health Function Select applicable	NOT AFFECTED	AFFECTED
Attention/Concentration	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Memory (short and/or long term)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Judgement (ability to make decisions)	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Mental Health Function - Additional Comments eg. effects of mental health symptoms, cognitive function:

NA

Other Functional Considerations - not listed above
NA

Other Functional Considerations - Additional Comments eg. effects of medication:

NA

Work Environment Considerations eg. physical (temperature, noise, space, light) or mental health considerations that affect work capacity
NA

Work Environment Considerations - Additional Comments eg. effects of medication:

NA

