

*Workers' Compensation and Injury Management Act 1981***CERTIFICATE OF DEGREE OF PERMANENT IMPAIRMENT**  
**[section 146H(1)]**

For	sfdasdfasdf asdfasdfad		
	Name of the worker.		
Address	eeee		
	6	Postcode	6
Date of birth			
	01 January 1980		
Date of injury			Insurer claim number
	10 December 2014		6
Description of injury			
	<div>1</div> <div>2</div> <div>3</div> <div>4</div> <div>5</div> <div>6</div> <div>7</div> <div>8</div> <div>9</div> <div>10</div> <div>11</div> <div>12</div> <div>1</div> <div>2</div> <div>3</div> <div>4</div> <div>5</div> <div>6</div> <div>7</div> <div>8</div> <div>9</div> <div>10</div> <div>11</div> <div>12</div> <div>1</div> <div>2</div> <div>3</div> <div>4</div> <div>5</div> <div>6</div> <div>7</div> <div>8</div> <div>9</div> <div>10</div> <div>11</div> <div>12</div>		
Contact telephone number			Email address
	6		f@gmail.com
WorkCover WA claim number			
	6		

*Workers' Compensation and Injury Management Act 1981***Employer's details**

Organisation name

REDiMED

Contact person

6

Address

1

6

Postcode 1

Telephone number

6

Email address

6

Name of Insurer

6

WorkCover number (if known)

6

**Purpose of the assessment** (Select only one below)**Schedule 2: Lump Sum Payments**

Assessment for the purpose of Part III Division 2A

☐**Common Law**Assessment for the purpose of Part IV Division 2  
Subdivision 3☒**Specialised Retraining Programs**

Assessment for the purpose of Part IXA

☐**Payment of Additional Medical Expenses: Exceptional Circumstances**

Assessment for the purpose of clause 18A of Schedule 1

☐

I certify that having assessed the above worker on 09-December  
2014 in accordance with the Workers' Compensation Injury  
Management Act 1981, the degree of permanent impairment for  
the injury detailed above is:

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*Workers' Compensation and Injury Management Act 1981*


12
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(Please state the degree of permanent impairment as a percentage. Also note for Schedule 2 Lump sum payments [Part III Division 2A] please specify the item number and the impairment description as per Part 2 of Schedule 2)

Signed:

Date

19-December  
2014

  
signed by the Approved Medical Specialist

Approved Medical Specialist

Dr. Hanh Nguyen

Address

s

s

Postcode s

Telephone number.

Email address

000

h@redimed

**Note: Copies of this certificate is to be forwarded to both the worker and employer.**