NTWorkSafe

FM19088

NORTHERN TERRITORY

Worker's Compensation Medical Certificate

FINAL CERTIFICATE

• Certificate to be given to worker • Doctor to retain a copy

Please complete all sections of this form

1. Worker Details				
Family Name:				
Given Name(s):				
Address:	Suburb: Postcode:		Telephone:	
Date of occurrence of injury or disease	Date: / /	Place:		

2. Employer Details		
Name of Worker's Employer:		
Employer's Address:	Suburb:	Postcode:

3. Medical Assessment (tick only those boxes which apply)

Time and date of this attendance:	☐ am / ☐ pm	Date: / /

Having examined the worker it is my opinion that as from:

Date: / /

- ☐ The worker has ceased to be incapacitated for work
- ☐ The worker's incapacity is no longer a result of the work-related injury / disease
- ☐ It is my opinion that the worker has fully recovered from the work related condition

Grounds for the opinions in medical assessment:

4. Medical Practitioner Details			
Name:		Registration No:	
Address:	Suburb: Postcode:		
Telephone:		Fax:	
Email:			

Signature: Date: / /