Form 4

WorkCover WA - FINAL certificate of capacity

1. WORKER'S DETAILS

First name	test	Last name	test
Date of birth	01/01/0001	Claim no.	
Phone		Email	
Address			

2. EMPLOYER'S DETAILS

Employer's name	Mineral Resources	Employer's phone	
Employer's address	1 Sleat Road, Applecross, Western Australia		

3. MEDICAL ASSESSMENT

Date of this assessment | Date of injury

☐ The worker's condition is unlikely to change substantially in the next 12 months

4. WORK CAPACITY

Having considered the health benefits of work, I find this worker to have:

☐ **full capacity for work** from ☐ but requires further treatment *(outline specifics below)*

☐ **capacity for work** performing ☐ hours per day and ☐ days per week from ☐

as outlined below: *(Please outline the worker's physical and/or psychosocial capacity for work, functional limits, ongoing need for workplace modifications, and/or further treatment needs)*

☐ lift up to ☐ kg
☐ sit up to ☐ mins
☐ stand up to ☐ mins
☐ walk up to ☐ m
☐ work below shoulder height

☐ **The worker's incapacity is no longer a result of the injury**

5. REASON FOR CAPACITY/INCAPACITY

Please outline your clinical reason for the worker's capacity/incapacity:

6. MEDICAL PRACTITIONER'S DETAILS

Name		AHPRA no. MED	
Address		Email	
		Signature	
Phone			
Fax		Date	

(Practice stamp – optional)