CLAIM ENQUIRIES
WorkCover Queensland 1300 362 128
Self insurance or other enquiries 1300 361 235

Queensland
Workers' compensation medical certificate

For general information about workers' compensation visit www.qcomp.com.au

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VERSION 4

PARTS A AND E OF THIS MEDICAL CERTIFICATE COMPRISE AN APPROVED FORM UNDER THE *WORKERS' COMPENSATION AND REHABILITATION ACT 2003*

Tick ☑ if applicable, and fill in the information as requested.

New claim

Claim number

PART A - Worker's details

I certify that on I attended to (given names)
(surname) (DOB)
Worker's daytime contact phone number
Worker's employer name
The worker is/was suffering from (list all medical/dental diagnoses relevant to the claim):
Diagnosis:

This is a provisional diagnosis (**if provisional complete Part B**)

Worker was first seen at this practice/hospital for this injury/disease on
Worker stated date of injury
Worker's stated cause of injury (if not previously supplied):

Injury/disease is consistent with worker's description of cause: Yes Uncertain
Detail any pre-existing factors or condition aggravated by the event (if not previously supplied):

Worker's capacity for work (not only pre-injury duties)

Please consider the *"health benefits of work"* when certifying the worker's capacity

To return to normal duties from
For suitable duties from to (**complete Part D**)
No capability for any type of work to (**complete Part C**)
Estimated time to return to some form of work duties: days weeks unsure

Medical management

Worker will require treatment from to (**complete Part C**)
Worker will be reviewed again on No further review required

PART B - Diagnostic plan

I have ordered: Diagnostic imaging Pathology Other investigations
Details:

PART C - Medical management plan

Treatment:
Medication prescribed:
Referred to specialist (specialty/name):
Referred to allied health professional (discipline/name):
Detail (specify):
I would like the insurer to arrange a case conference with (tick more than one if appropriate)

Treating practitioner Treating Specialist Treating Allied Health Employer
Employer has been contacted
I would like the insurer to contact me

Further information:

PART D - Rehabilitation and return to work plan

Approval is given for a suitable duties program with the following guidelines

	No	Occasional	Frequent	Comments
Lifting: weight limit kg				
Bending/twisting/squatting				
Standing/sitting				
Use of injured hand/arm				
Pushing/pulling				
Operating machinery /heavy vehicle				
Driving a car				
Keep wound clean and dry				

Other considerations (specify):
Restricted hours/days (specify):

I require a suitable duties program to be provided to me for approval

PART E - Medical/Dental practitioner details (please print clearly or use practice or hospital stamp)

Doctor's name: Practice/hospital name:
Postal address:
Preferred method of contact: Ph: day(s)/time(s)
Fax: Email:
Signature: Date: / /

Practice/hospital stamp here