REDiMED TOTAL INJURY MANAGEMENT

FORM 4 Workers' Compensation and Rehabilitation Act 1981(Section 61(1))

WorkCover WESTERN AUSTRALIA

Workers' Compensation FINAL Medical Certificate

1. To (name and address of worker's employer)

Claim No.
(If Known)

2. Time & Date of this Examination:

3. Worker's Details
First name(s): Surname:
Address:
Telephone:
Date and place of occurrence of disability:

4. Medical Assessment

Having examined the worker, it is my opinion that as from:
☐ the worker has wholly recovered from the effects of the disability.
☐ the worker has partially recovered from the effects of the disability.
☐ the worker's incapacity is no longer a result of the disability.

It is also my opinion that as from the worker is:
☐ fit.
☐ fit for alternative duties with the following limitations:

Grounds for the opinion in medical assessment:

Claim is capable of finalisation
☐ No permanent impairment
☐ Permanent impairment present

5. Medical Practitioner's Details
Name: Registration No:
Address:
Telephone:
Fax:

Signature:

For workers' compensation information or assistance contact
WorkCover WA's Infoline: 08 9388 5555 Country callers: 1 800 670 055