Purple – Insurer's copy
Brown – Worker's copy
Green – Doctor's copy

INITIAL
Workers Compensation Medical Certificate

Section 34(1)(b) of the Workers Rehabilitation and Compensation Act 1988

WorkCover TASMANIA

PLEASE PRINT

1. Initial Medical Certificate Completion

This form is to be completed for INITIAL consultations only
If it is NOT the patient's first consultation a CONTINUING/FINAL Workers Compensation Medical Certificate must be completed
All sections of this form must be completed unless stated otherwise

2. Worker's Name

3. Employer's Name

4. Medical Assessment

I examined the above worker on ...../...../.....

Presenting Symptoms:

.....
.....

Diagnosis: ☐ **Provisional** ☐ **Final**

Details (do not restate symptoms):

.....
.....

5. Stated Cause

The abovenamed worker stated the condition to be caused by:

☐ an incident which occurred on ...../...../.....

☐ a disease, symptoms of which became evident on ...../...../.....

The worker stated that the injury or disease occurred under the following circumstances:

.....
.....
.....

The injury or disease is:

☐ consistent with the stated cause

☐ inconsistent with the stated cause Give reasons:

.....
.....

☐ of uncertain cause Give reasons:

.....
.....

If known, the injury or disease is: (Refer to explanatory notes on cover for definitions)

☐ a recurrence of a previously compensable condition
☐ an aggravation of an existing condition
☐ a new condition

Past history of similar injury or comments relevant to condition:

.....
.....

6. Workplace Contact

Has the workplace/employer been contacted to discuss management and/or restrictions?

☐ YES ☐ NO

Workplace Contact ...../...../..... Date

7. Capacity to Work

Prior to determining work capacity it is recommended that the worker's employer/workplace is contacted (refer previous)

Note: Capacity is determined by the medical practitioner's assessment not by the availability of work in the workplace

I consider the worker:

☐ Has not been incapacitated for work and is fit for pre-injury duties **(proceed to 9)**

☐ Requires treatment but is fit for pre-injury duties **(proceed to 8)**

☐ Is fit for suitable duties (Refer to explanatory notes on cover for definition)
from ...../...../..... to ...../...../.....

Please indicate any restrictions that should apply: (eg: transport restrictions, restriction of hours, need for rest breaks, limb and mobility restrictions)

.....
.....

(proceed to 8)

☐ Will be incapacitated for **any** work from
...../...../..... to ...../...../.....

If greater than 14 days give reasons together with an appointed review date at **Section 8**:

.....
.....

☐ Will cease to be incapacitated for work on ...../...../.....
(proceed to 9)

8. Medical Management

Has the worker consulted any other health professionals regarding these symptoms?

☐ YES Details:
.....
.....
☐ NO

Treatment/medication/investigations:

.....
.....

I have referred the worker to: (usual GP/other health professionals)

Name of provider:

Details:

I wish to review the worker

☐ YES On ...../...../.....

☐ NO Injury is minor and no further intervention is required (first and final consultation)

9. Signatures

Worker's consent to contact and discuss matters in this certificate with employer, including any agent of the employer:

Signature: ...../...../..... Date

WorkCover Accredited Medical Practitioner

Signature: ...../...../..... Date

10. WorkCover Accredited Medical Practitioner Details

Name:
Address:

Phone: Fax:
GP/Specialty: Provider No:

Once all sections have been completed please ensure that the worker's copy is placed inside the envelope provided by WorkCover Tasmania