Worker's Compensation Medical Certificate

FIRST CERTIFICATE – up to 14 days

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

Worker Details			
Family Name:		Date of birth:	/ /
Given Name(s):			
Address:	Suburb:		Postcode:
Telephone:		Occupation:	

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

Injury Details (from worker)	
Date of injury or disease first noticed:	/ /
Workplace location where injury or disease occurred:	
Worker's description of the injury or disease:	
Worker's description of how the injury or disease occurred:	

Medical Assessment (tick only those boxes which apply)		
Time and date of examination:	am/pm	Date: / /
In my opinion the injury or disease is:	☐ Consistent with stated cause	☐ Inconsistent with stated cause
☐ Of uncertain cause (comment):		
History of current condition:		
Prior History (relevant to current condition):		
Examination:		
Investigations:		
Diagnosis:		
Complications:		

Fitness for Work (tick only those boxes which apply)

In my opinion that as from the date of this certificate the worker is:

- ☐ **Fit** to return to ***pre-injury duties, no further treatment*** required
- ☐ **Fit** to return to ***pre-injury duties***, but ***requires further treatment***
- ☐ **Fit** to return to work for restricted hours / days from:
  _____ / _____ / _____ to _____ / _____ / _____ (inclusive) _____ hours per day _____ hours per week.
- ☐ **Fit** to return to work **on restricted duties** from:
  _____ / _____ / _____ to _____ / _____ / _____ (inclusive)

  Restricted Duties
  - ☐ Avoid prolonged Standing / walking / sitting
  - ☐ Avoid squatting / kneeling / ladders / steps
  - ☐ No lifting anything heavier than ☐ 5, ☐ 10, ☐ 15 or ☐ 20 kg
  - ☐ Avoid repetitive use of affected body part
  - ☐ Avoid repetitive bending / lifting
  - ☐ Other:
- ☐ **Totally unfit for work from** _____ / _____ / _____ to _____ / _____ / _____ (inclusive)

Is this a FIRST and FINAL Certificate:	☐ YES	☐ NO

Injury Management (tick only those boxes which apply)

1. Medical Practitioner / Employer Contact

- ☐ I have made contact with the employer and discussed alternative work options.
- ☐ The worker will require more than three days off work, consequently I will be happy to discuss this further with the employer / insurer. Preferred contact times: Day(s) _____ Time(s) _____

2. Medical Management Plan

- ☐ Treatment:
- ☐ Medication:
- ☐ Referral to Specialist (specialty / name):
  Date of Appointment: / / Time: am/pm
- ☐ Referral to Hospital (specify):
- ☐ Referral to AHP (Allied Health Professional/s):
  - ☐ Physiotherapist (name):
    Number of sessions recommended:
  - ☐ Chiropractor (name):
    Number of sessions recommended:
  - ☐ Other (specify):
- ☐ Case Conference Recommended (specify):

Vocational Rehabilitation Referral: ☐ may be necessary ☐ may not be necessary

3. Review Date

Worker to be reviewed on: / /

Medical Practitioner Details

Name:		Registration No:	
Address:		Suburb:	Postcode:
Telephone:		Fax:	Email:

Signature: Date: / /