NTWorkSafe

FM19101

NORTHERN TERRITORY

Worker's Compensation Medical Certificate

PROGRESS CERTIFICATE

– Recommended maximum 28 days duration

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

NOTE: Maximum referral period for rehabilitation treatment prior to review is initially 14 days, and 28 days for subsequent referrals to the same discipline.

1. Worker Details

Family Name:	
Given Name(s):	
Address:	
Telephone:	
Date of injury or disease:	/ /
Date of birth:	/ /

2. Employer Details

Name of Worker's Employer:

Employer's Address:

3. Medical Assessment

Time and date of examination:

Time: ☐ am / ☐ pm Date: / /

Clinical findings / diagnosis at this examination:

4. Fitness for Work (tick only those boxes which apply)

Fit

☐ **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 restrictions: _____
- ☐ Duties recommended / capable: _____

Unfit

☐ Totally unfit for work for _____ days

from _____ / _____ / _____ to _____ / _____ / _____ (inclusive)

☐ I will review the worker (date of next appointment)

_____ / _____ / _____

5. Injury Management (tick only those boxes which apply)

Medical Practitioner / Employer Contact

☐ I have made contact with the employer and discussed alternative work options

OR

☐ The worker will require more than three days off work, consequently I will be happy to discuss this further with the employer / insurer. * Please note my preferred contact times below

Medical Management Plan

☐ Medication: (please specify):

☐ Physiotherapy / Chiropractor ☐ Imaging

☐ Other: (please specify)

☐ Referred to specialist. Name:

Specialty:

☐ Referred to hospital (Name):

☐ Surgery likely in the future

Other comments:

Vocational Rehabilitation

Options MUST be discussed with the Worker

☐ Likely to be necessary, subject to review in _____ weeks

☐ I would like the employer / insurer to organise a referral and discuss with me. * Please note my preferred contact times below

6. Medical Practitioner Details

Name:	
Registration No:	
Address:	
*Preferred Contact Times Days: Times:	
Telephone:	
Fax:	

Signature: Date: _____ / _____ / _____

Northern Territory Government