Form 4A

WorkCover WA - PROGRESS certificate of capacity

1. WORKER'S DETAILS

First name	1	Last name	1
Date of birth	01/01/0001	Claim no.	
Phone		Email	
Address			

2. EMPLOYER'S DETAILS

Employer's name	Mineral Resources	Employer's phone	
Employer's address	1 Sleat Road, Applecross, Western Australia		

3. MEDICAL ASSESSMENT

Date of this assessment	12/12/2014	Date of injury	
Diagnosis			

4. PROGRESS REPORT

Activities/interventions	Actual outcome *(change in symptoms, function, activity and work participation)*	Still required?*	
c	sv	☐ Yes	☑ No
cxbcv	v	☑ Yes	☐ No
vz	xvzx	☑ Yes	☐ No
vzxv	xzvxzv	☐ Yes	☑ No
		☐ Yes	☐ No
		☐ Yes	☐ No

**(If management activities/interventions are still required, please also list them in Section 6 'Injury Management Plan')*

☐ Other factors appear to be impacting recovery and return to work

Comment: Dead space

5. WORK CAPACITY

Worker's usual duties: Dead space

Having considered the health benefits of work, I find this worker to have:

☐ **full capacity for work** from ____ ☐ but requires further treatment

☑ **some capacity for work**, from 19/12/2014 to 24/12/2014 performing:

- ☐ pre-injury duties
- ☐ modified or alternative duties
- ☑ workplace modifications
- ☑ pre-injury hours
- ☐ modified hours of 2 hrs/day 2 days/wk

☐ **no capacity for any work** from ____ to ____ *(outline clinical reason on next page)*

5. WORK CAPACITY (CONTINUED)

Worker has capacity to:

(Please outline the worker's physical and/or psychosocial capacity – refer to explanatory notes for examples. Where there is no capacity for work, please provide clinical reasoning.)

- ☐ lift up to 2 kg
- ☐ sit up to 2 mins
- ☐ stand up to 2 mins
- ☐ walk up to 2 m
- ☐ work below shoulder height

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6. INJURY MANAGEMENT PLAN

Activities/interventions	Purpose/goal *(likely change in symptoms, function, activity and work participation)*
Dead space	Dead space
	Dead space
	Dead space

- ☑ I support the RTW program established by the employer/insurer/WRP dated 17/12/2014
- ☑ I would like more information about available duties
- ☑ I would like to be involved in developing the RTW program
- ☑ Please engage a workplace rehabilitation provider *(If you have made a referral, provide name and contact details below)*

Examples of injury management activities/interventions include:

- *further assessment - diagnostic imaging, medical specialist consults, worksite assessment*
- *intervention - physiotherapy, clinical psychology, exercise physiology, prescribed medications, workplace mediation*
- *return to work planning - identify suitable duties, establish return to work program*

7. NEXT REVIEW DATE

☐ I will review worker again on 10/12/2014 *(if greater than 28 days, please provide clinical reasoning)*

Comments

8. MEDICAL PRACTITIONER'S DETAILS

Name: Pre Employment 1

Address:

Phone:

Fax:

(Practice stamp – optional)

AHPRA no. MED: 12122121

Email: saasas@yahoo.com

Signature: 

Date: 12/12/2014