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

CONTINUING/FINAL Workers Compensation Medical Certificate

Section 69(1) of the Workers Rehabilitation and Compensation Act 1988

WorkCover TASMANIA

PLEASE PRINT

1. Continuing/Final Medical Certificate Completion

This form is to be completed for all visits subsequent to an initial consultation

If it is the patient's FIRST consultation an INITIAL 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 ...../...../.....

Current symptoms:

Current diagnosis:

Has the diagnosis changed? ☐ YES ☐ NO

If yes provide details:

5. Workplace Contact

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

☐ YES ☐ NO

Workplace Contact | Date

6. Capacity to Work

Prior to determining work capacity it is recommended that the worker's employer/workplace is contacted (refer above)
Note: Capacity is determined by the medical practitioner's assessment not by the availability of work in the workplace

I consider the worker:

☐ Requires further 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 ...../...../..... **(proceed to 7)**

☐ 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)**

☐ Is fit for ongoing suitable duties from ...../...../.....

Are duties permanent? ☐ YES ☐ NO **(proceed to 7)**

7. Return to Work

Full-time ☐ YES ☐ NO
Graduated ☐ YES ☐ NO

(insert week)	Week ☐ to Week ☐		Week ☐ to Week ☐	
Hours/Day				
Days/Week				

7. Return to Work Continued

Are rest breaks required?

☐ YES ☐ mins every ☐ hr(s) ☐ NO

Please indicate areas of reduced capacity:

Use arm(s)	☐ YES	☐ NO
Elevate arm(s)	☐ YES	☐ NO
Lift weight	☐ YES	☐ NO
Bend/squat/twist	☐ YES	☐ NO
Pull/push	☐ YES	☐ NO
Climb	☐ YES	☐ NO
Sit	☐ YES	☐ NO
Stand	☐ YES	☐ NO
Drive/operate machinery	☐ YES	☐ NO
Use public transport	☐ YES	☐ NO
Other	☐ YES	☐ NO

Comments: (if YES comment on restrictions e.g. capacity for repetitive actions)

Are there any other impediments to return to work?
(eg: psychological, external factors or assistance to be provided)

☐ YES Details:
☐ NO

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:

Is any procedure likely?

☐ YES Details:

☐ NO Date procedure scheduled ...../...../.....

I wish to review the worker

☐ YES On ...../...../.....

☐ NO Medical treatment has ceased and no further intervention is required (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: