

# Workers' compensation – final medical certificate

SAMPLE ONLY

*Yellow copy – for worker  
White copy – doctors record*

# Workers' compensation - final medical certificate

Please complete all sections of this form

## 1. Worker details

Surname: \_\_\_\_\_

Given Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Date and place of occurrence of injury or disease:      /      /      \_\_\_\_\_

(place of occurrence)

## 2. Employer details

Name and address of worker's employer: \_\_\_\_\_

\_\_\_\_\_

## 3. Medical assessment (Tick only those boxes which apply)

Time and date of this attendance: \_\_\_\_\_ am/pm      /      /

Having examined the worker it is my opinion that as from      /      /

- The worker has ceased to be incapacitated for work.
- The worker's incapacity is no longer a result of the work related injury/disease.
- It is my opinion that the worker has fully recovered from the work related condition.

Grounds for the opinions in medical assessment: \_\_\_\_\_

\_\_\_\_\_

## 4. Medical practitioner details

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Registration Number: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature: \_\_\_\_\_ Date:      /      /

putting safety first >

