

Workers' compensation medical certificate

First certificate up to 14 days

SAMPLE ONLY

*Pink and green copies - for worker - attach to compensation claim
White copy - doctors record*

Workers' compensation medical certificate

First certificate - up to 14 days

Please complete all sections of this form

Worker Details			
Surname:		Given Name(s):	
Address:			
Telephone:	Occupation:	Date of Birth:	/ /
Employer Details			
Name of worker's employer:			
Employer's address:			
Injury Details (from worker)			
Date of injury/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 <i>(Tick only those boxes which apply)</i>			
Time and date of examination:		am/pm	/ /
I my opinion the injury or disease is:			
<input type="checkbox"/> Consistent with the stated cause		<input type="checkbox"/> Inconsistent with the stated cause	
<input type="checkbox"/> 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)*

It is 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 20kg **Avoid** repetitive use of affected body part **Avoid** repetitive bending/lifting **Other:**

Is this a FIRST and FINAL Certificate?

 Yes **No** **Totally unfit for work** from / / to / / (inclusive)**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) Referred 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/may not be necessary**3. Review Date**

Worker to be reviewed on / /

Medical Practitioner Details

Name: Registration No:

Address:

Telephone: Fax:

Signature:

Date: / /

