CERTIFICATE OF CAPACITY

Authority logo

Version number / date

This certificate is the approved form for a compensable injury or illness covered by Workers' Compensation or Compulsory Third Party Insurance.

- Your doctor needs to report your capacity to perform functional tasks.
- Your employer needs to use this information to find suitable duties.
- Participating in good, safe work is an important part of your recovery.

1. Patient details

First name

Last name

Address (must be a residential address, not PO Box)

Suburb

Date of birth ☐☐/☐☐/☐☐☐☐

State ☐☐☐ Postcode ☐☐☐☐

Claim number (if known)

Occupation/job title

Employer's name (if applicable)

2. Diagnosis

Examination date ☐☐/☐☐/☐☐☐☐

Date of injury ☐☐/☐☐/☐☐☐☐

Is this a new injury or illness? ☐ Yes ☐ No

Injury/illness is consistent with my patient's description of cause ☐ Yes ☐ No ☐ Unclear

Diagnosis / diagnoses of injury/illness

3. Management plan

Treatment & Services *Required to support my patient's recovery and return to work following injury*

Referral I have referred you for the following treatment:

- ☐ Medical specialist (Name & specialty)
- ☐ Psychologist (Name)
- ☐ Physiotherapist (Name)
- ☐ Other (Name & discipline)

☐ Capacity for work and other activities **is affected** by injury/illness – continue to *Section 4*

☐ Capacity for work and other activities **is unaffected** – continue to *Section 5*

4. Capacity assessment – Select applicable and provide relevant detail

Physical function *Select applicable*	CAN	PARTIALLY AFFECTED	CANNOT	**Further physical function comments**
Sit	☐	☐	☐	
Stand/Walk	☐	☐	☐	
Bend	☐	☐	☐	
Squat	☐	☐	☐	
Kneel	☐	☐	☐	
Lift	☐	☐	☐	
Stairs/climbing	☐	☐	☐	
Neck movement	☐	☐	☐	
Reach above shoulder	☐	☐	☐	
Use injured arm/hand	☐	☐	☐	
Drive	☐	☐	☐	
Other (provide details)	☐	☐	☐	

Psychosocial function *Select applicable*	CAN	PARTIALLY AFFECTED	CANNOT	**Further mental health function comments**
Concentrate/maintain attention/memory	☐	☐	☐	
Do regular activities/maintain energy levels	☐	☐	☐	
Tolerate everyday frustrations/cope	☐	☐	☐	
Other (provide details)	☐	☐	☐	

Other factors affecting capacity e.g. effects of medication, environment or other factors which affect capacity

5. Certification

Taking account of the capacity assessment in section 4, my patient:

☐ can stay at work

☐ can return to pre-injury work from ☐☐/☐☐/☐☐☐☐

☐ can return to suitable work from ☐☐/☐☐/☐☐☐☐ to ☐☐/☐☐/☐☐☐☐

Comments and modifications – including gradual return to work requirements, hours of work, suitable duties and reasonable adjustments

Hours

☐ cannot return to any work from ☐☐/☐☐/☐☐☐☐ to ☐☐/☐☐/☐☐☐☐

Comments and modifications – including gradual return to work requirements, hours of work, suitable duties and reasonable adjustments

Review date
(if more than 14 days incapacity)
☐☐/☐☐/☐☐☐☐

Estimated timeframe to return to work ☐☐ *days or* ☐☐ *weeks*

Other factors affecting recovery

☐ I have discussed with my patient the different types activities they may (or may not) be able to perform in the workplace

6. Provider declaration

I certify that I have examined the patient. The information and medical opinions I have provided in this certificate are, to the best of my knowledge, true and correct.

Provider details *(or practice stamp)*

Signature of Provider

Provider no. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Date issued ☐☐/☐☐/☐☐☐☐

7. Patient consent

I consent to my treating medical practitioner, my employer, the insurer, other medical practitioners or health related practitioners (whether consulting, treating or examining), workplace rehabilitation providers and ORGANISATION exchanging information for the purposes of managing my injury and workers' compensation claim. I understand this information will be used by ORGANISATION and insurers to fulfil their functions under the workers' compensation legislation.

Signature

Date

☐☐/☐☐/☐☐☐☐