**CERTIFICATE OF CAPACITY**

Certificate text as preferred by jurisdiction. Information that could be covered in this section include:

* Detail of relevant legislation
* Purpose of certificate
* Statement outlining importance/relationship of work as part of recovery / health benefits of work

Authority logo

Tick if this is the initial certificate for this claim

|  |
| --- |
| 1. Patient details – may be completed by patient |

Claim number (if known)

First name

Last name

/

/

/

/

Date of injury

Date of birth

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

Postcode

State

Suburb

Occupation/job title

Employer’s name

|  |
| --- |
| 2. Diagnosis – to be completed by nominated treating doctor or specialist medical practitioner |

Diagnosis of work related injury/illness

Yes

No

Is this a new injury or condition?

Examination date

/

/

Injury/illness is consistent with worker’s description of cause

Yes

Unclear

|  |
| --- |
| 3. Capacity assessment – note: If capacity is affected further details MUST be provided in this section. Continue to Section 4 if capacity unaffected |

**Work capacity is affected by work related injury/illness as follows:** *Select applicable and provide relevant detail*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Physical function** *Select applicable*  | **CAN** | **WITH MODIFICATIONS** | **CANNOT** | **Physical function detail** |
| Sit |  |  |  |  |
| Stand/Walk |  |  |  |  |
| Bend |  |  |  |  |
| Squat |  |  |  |  |
| Kneel |  |  |  |  |
| Driving |  |  |  |  |
| Reach above shoulder |  |  |  |  |
| Use injured arm/hand |  |  |  |  |
| Lift |  |  |  |  |
| Neck movement |  |  |  |  |
|  |  |  |  |  |
| **Mental health function***Select applicable* | **NOT AFFECTED** | **PARTIALLY AFFECTED** | **AFFECTED** | **Mental health function detail** |
| Attention/concentration |  |  |  |  |
| Memory (short and/or long term) |  |  |  |  |
| Judgement (decision ability) |  |  |  |  |

**Additional comments** *e.g. effects of medication, cognitive function, environmental factors or other considerations that affect work capacity*

|  |
| --- |
| 4. Certification |

/

/

to

has a capacity for suitable employment from

/

/

has a capacity for pre-injury employment from

/

/

Taking account the capacity assessment in section 3, the patient:

Comments – including gradual return to work requirements

to

has no capacity for employment from

/

/

/

/

Estimated timeframe to return to work days or weeks

Factors delaying recovery

|  |
| --- |
| 5. Treatment plan |

**Treatment/medication type and duration** – including injury management, strategies to increase capacity for work, address return to work barriers and/or prevent reoccurrence/aggravation of injury/illness

|  |  |  |
| --- | --- | --- |
| **Treatment type**  | **Purpose** | **Frequency and/or duration** |
|  |  |  |

**Referral to another health care provider** – provide details of provider and service requested, duration and frequency where relevant

|  |  |  |
| --- | --- | --- |
| **Referral provider** | **Service requested** | **Frequency and/or duration** |
|  |  |  |

|  |
| --- |
| 6. Certifier declaration |

I certify that I have clinically 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 Certifier

Provider no.

Date issued

/

/

|  |
| --- |
| Supplementary section if applicable |
| *Please refer next page* |

|  |
| --- |
| Further information – SAMPLE TEXT ONLY (jurisdictionally-specific) |
| **RETURNING TO WORK**If you have a work capacity for suitable employment your employer and case manager will use the information provided by your certifier on the Certificate of Capacity to assess suitable options for you to safely stay or return to work. They will take into account what you can do safely and any limitations that apply to your individual circumstances.  | **PRIVACY**ORGANISATION will handle your personal and health information in accordance with privacy policies and legislation. You can access ORGANISATION’s privacy policy information at www.sample.gov.au |

**Supplementary sections**

NSW

|  |
| --- |
| 7. Patient declaration and consent |

**MANDATORY unless this is the initial certificate or an attendance certificate only**

At any time since the last Certificate of Capacity, have you engaged in any form of paid employment (other than with your pre-injury employer as part of your return to work), self-employment or voluntary work for which you have received or are entitled to receive payment in money or otherwise since the last certificate was provided?

No, I have not

Yes, I have - please provide details

**I declare that the details I have given on this certificate are true and correct. I understand it is an offence under the legislation to provide false or misleading information.**

**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.**

Date

/

/

Signature

WA and Tasmania

|  |
| --- |
| 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.**

Date

/

/

Signature of worker

Victoria

|  |
| --- |
| 7. Patient declaration  |

**MANDATORY unless this is the initial certificate or an attendance certificate only**

At any time since the last Certificate of Capacity, have you engaged in any form of paid employment (other than with your pre-injury employer as part of your return to work), self-employment or voluntary work for which you have received or are entitled to receive payment in money or otherwise since the last certificate was provided?

No, I have not

Yes, I have - please provide details

**I declare that the details I have given on this certificate are true and correct. I understand it is an offence under the legislation to provide false or misleading information.**

/

/

Signature

Date