WORKCOVER NSW
MEDICAL CERTIFICATE

☐ **Initial** ☐ **Progress** ☐ **Final**

NB: Questions in italics need not be completed on subsequent certificates unless there is new information.

1. WORKER DETAILS (may be completed by the injured worker) Claim No.: _____

Family name: _____ Other names: _____

Address: _____

Postcode: _____ *Phone No.:* _____ *Date of birth:* ____/____/____

Employer name: _____

Address: _____ *Postcode:* _____

Occupation: _____ *hrs / week:* _____

How the injury occurred: _____

_____ *Date of injury:* ____/____/____

2. MEDICAL CERTIFICATION

Diagnosis: _____

In my opinion, the worker's employment is a substantial contributing factor to this injury: ☐ *Yes* ☐ *No* ☐ *Unknown*

Management plan: _____

_____ Treatment review date: ____/____/____

3. FITNESS FOR WORK: The worker:

☐ is fit for pre-injury duties ☐ is unfit to work from ____/____/____ to ____/____/____

☐ is fit for suitable duties from ____/____/____ to ____/____/____

☐ has reached maximum medical improvement and is fit for permanently modified duties from ____/____/____ (final certificate only)

An assessment of workplace duties **is / is not** required. Date of examination ____/____/____

The worker has the following **capabilities for** _____ hrs / day _____ days / week

Lifting up to _____ Walking up to _____

Sitting up to _____ Standing up to _____

Travelling up to _____ Keying up to _____

Other: _____

Fitness for work will be reviewed on: ____/____/____

4. MEDICAL PRACTITIONER DETAILS

Name: _____ Provider No.: _____

Address: _____

_____ Postcode: _____

Phone No.: _____ Fax No.: _____

I agree to be this worker's Nominated Treating Doctor and to assist in his / her return to work ☐ *Yes* ☐ *No*

Signature: _____ Date: ____/____/____

5. INJURED WORKER CONSENT

I confirm the information I have given is correct; I nominate _____ *as my Nominated Treating Doctor; I consent to my Nominated Treating Doctor, my employer, the insurer, other treating practitioners, rehabilitation providers and WorkCover NSW exchanging information for the purposes of managing my injury and workers compensation claim. I understand this information will be used by WorkCover and insurers to fulfil their functions under the workers compensation legislation.*

Signature: _____ Date: ____/____/____