



Australian Government

Comcare

PUTTING YOU *FIRST*

MEDICAL CERTIFICATE FOR WORKERS' COMPENSATION

Comcare is the workers' compensation insurer for Commonwealth and ACT Government employees. It administers a workers' compensation scheme aimed at reducing the human and financial costs of occupational injury and disease. The scheme empowers employers to work with their employees to maintain an injured employee at work or to achieve an early, safe and durable return to work.

Please note that medical certificates can be completed for periods up to 12 months. However, Comcare may require further medical evidence during this period.

Please complete all sections of the form. 'As previous' or 'Unchanged' is not considered sufficient information.

EMPLOYEE'S DETAILS

Family name

Given name

Date of birth

Comcare claim reference no

Address

Phone (home)

(work)

MEDICAL CERTIFICATION

Initial certificate

Continuing certificate

Final certificate (tick appropriate box)

I examined the patient on

Current clinical symptoms/diagnosis

Based on the patient history, in my opinion this current condition is caused by:

Sustained on

Fitness for work (treating Doctor to Complete)

The claimant is currently:

fit to continue pre-injury duties

fit to return to pre-injury duties from

fit for modified duties, with limitations specified below, from to

Restrictions (such as lifting, walking, standing, keying, and hours per day)

totally unfit for work from to
due to:

(Please specify reasons for total incapacity)

CURRENT MEDICAL TREATMENT SUMMARY

What type of medical treatment or pharmaceutical treatment is currently required for this condition?

For treatment recommended above, please specify details as follows:

Treatment type No. of sessions

Date of next review

Detailed description

Benefits of treatment

Treatment type

No. of sessions

Date of next review

Detailed description

Benefits of treatment

Treatment type

No. of sessions

Date of next review

Detailed description

Benefits of treatment

MEDICAL PRACTITIONER'S DETAILS

Stamp
(Please affix
stamp here)

Name and address of registered medical practitioner (please print)

Name

Address

Phone

Fax

Qualifications

Specialty

Provider number

Signature

Date