MEDICAL CERTIFICATE FOR COMPENSATION

Australian Government
Comcare

PRIVACY INFORMATION

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1. EMPLOYEE'S DETAILS

Surname

Given names

Date of birth / /

Claim number

2. EXAMINATION AND DIAGNOSIS

(Please complete all sections. The use of 'as previous' and 'unchanged' is not sufficient information)

☐ Initial certificate ☐ Continuing certificate ☐ Final certificate
(tick appropriate box)

Date of examination / /

Date patient was first seen at this practice in relation to this condition / /

Sustained on / /

Current clinical symptoms/diagnosis *(Please note that 'pain' is not a diagnosis)*

Based on the information available to me, this was caused by

Injury/disease is consistent with employee description of cause

☐ yes ☐ no ☐ uncertain

Pre-existing or contributing factors

This condition is to be reviewed again on / /

3. FITNESS FOR WORK

I find this employee (tick appropriate box(es) and complete as necessary)

☐ is fit to continue pre-injury duties

☐ is fit to return to pre-injury duties from / /

☐ is fit for modified duties from / / to / /

for hrs/day days/wk

with the following limitations

Lifting up to kg

Travelling up to hrs:mins

Standing up to hrs:mins

Sitting up to hrs:mins

Walking up to kms

Keying up to hrs:mins

Other

☐ is unfit to work from / / to / /

4. MEDICAL MANAGEMENT *(Pharmaceuticals, specialist referral, imaging, allied health care—please include frequency i.e fortnightly)*

MEDICAL TREATMENT	FREQUENCY	REASON	END/REVIEW DATE

5. MEDICAL PRACTITIONER'S DETAILS *(please use stamp where possible)*

please sign and affix doctor's stamp here

Doctor's signature