Australian Government

Certificate of capacity for work

Part A – Provides a medical assessment of your work capacity

First name _____ Last name _____ Date of birth ___/___/___

Current occupation _____ Date assessed ___/___/___

Clinical symptoms/diagnosis_____

_____

Comments on physical capacity
Comments on mental capacity
Comments on other issues impacting recovery or return to work

I recommend that: ☐ you are fi**t for work** from ___/___/___ to ___/___/___

☐ you are **fit for work** from ___/___/___ to ___/___/___ with the following

☐ graduated return to work Provide details _____

☐ modified duties Provide details _____

☐ reduced hours Provide details _____

☐ workplace adjustments Provide details _____

☐ return to work plan (attached)

☐ you are **not fit for work** from ___/___/___ to ___/___/___

Reason unfit for work:_____

I recommend the following **medical management and/or work rehabilitation:**

Treatment, medications, investigation or referral	Purpose	Frequency

Next review date___/___/___

Clinical reasoning (if >28 days):_____

Comcare 1/2016 Patient's name

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Part B – Provides additional information for your insurer, if the certificate relates to a claim for compensation

Claim number_____ First seen in relation to this condition at this practice on ___/___/___

Date injury was sustained/disease was contracted ___/___/___

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

The injury/disease is ☐ an aggravation of a pre-existing condition ☐ a new injury/disease

☐ a continuing injury/disease

Factors which may be relevant to the condition or recovery (if any) are

List work environment, social or personal circumstances that are relevant to the recovery and RTW, as well as other medical conditions

☐ To assist recovery and return to work I request a return to work case conference with the employer and the employee

This certificate is ☐ an initial certificate ☐ a continuing certificate ☐ a final certificate

☐ I have discussed the information contained in this form with the named patient and they agree to the form being provided to their employer and/or insurer

Part C – Medical practitioner's details

Please affix practice stamp here or provide contact details and provider number.

Medical practitioner's signature: _____

Date ___/___/___