

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: ____/____/____