WorkCover

WorkCover NSW – certificate of capacity

Please ensure all sections are completed. Tick if this is the initial certificate for this claim ☐

PART A – MAY BE COMPLETED BY PATIENT

Patient's first name

Last name

Date of birth (DD/MM/YYYY)

Patient's address

Claim number

Medicare number

[redacted]

PART B – TO BE COMPLETED BY NOMINATED TREATING DOCTOR OR TREATING SPECIALIST MEDICAL PRACTITIONER

MEDICAL CERTIFICATION

[redacted]

Em r's name and contact details

[redacted]

Claimant name

Claim number

MANAGEMENT PLAN FOR THIS PERIOD

CAPACITY FOR EMPLOYMENT (Please consider the health benefits of work when completing this section)

Do you require a copy of the position description/work duties? ☐ Yes ☐ No

Patient:

☐ is fit for pre-injury duties

☐ has capacity for some type of employment from

☐ has no current work capacity for any employment from

Do you recommend referral to workplace rehabilitation provider? ☐ Yes ☐ No

Referral to another health care (provide details of provider and service duration and fee

TREATING MEDICAL PRACTITIONER DETAILS

☐ Please tick if you agree to be the nominated treating doctor for the ongoing management of this injury

WorkCover NSW – certificate of capacity

PART 2 – TO BE COMPLETED BY THE WORKER PRIOR TO SENDING TO THE EMPLOYER OR INSURER (this page)

WORKER DECLARATION

Worker's first name

Last name

Date of birth (DD/MM/YYYY)

Worker's address

Claim number

I ☐ have ☐ have not (tick appropriate box)

engaged in any form of paid employment, self employment or voluntary work for which I have received or am entitled to

involve the nominated treating doctor/treating specialist)

I declare that the details I have given on this declaration are true and correct, knowing that false declarations are