Certificate of capacity/ certificate of fitness

NSW GOVERNMENT | State Insurance Regulatory Authority

For use with workers compensation and Compulsory Third Party (CTP) motor accident injury claims.

☐ CTP ☐ Workers compensation

For CTP claims: 'Certificate of fitness' means 'certificate of fitness for work'. This certificate should be completed whether the person was employed at the time of the accident or not.

☐ Tick if this is the initial certificate for this claim.

Section 1: To be completed by the injured person or treating medical practitioner

First name

Last name

Date of birth (DD/MM/YYYY)

Telephone number

Address (must be residential address – not PO Box)

Suburb

State

Postcode

Claim number

Medicare number

Occupation/job title

Employer's name and contact details (if applicable)

Injured person's consent

I consent to my treating medical practitioner, my employer (optional for CTP claims), the insurer, other medical practitioners or health related practitioners (whether consulting, treating or examining), workplace rehabilitation providers and SIRA exchanging information for the purpose of managing my injury and workers compensation/motor accident injury claim.

I understand this information will be used by SIRA and insurers to fulfill their functions under the motor accident insurance and workers compensation legislation.

Signature

Date (DD/MM/YYYY)

Section 2: To be completed by treating medical practitioner

Medical certification

Diagnosis of work related injury/disease or motor accident related injury(ies)

Person's stated date of injury/accident (DD/MM/YYYY)

Shaded areas to be completed for initial certificate only

Person was first seen at this practice/hospital for this injury on (DD/MM/YYYY)

Injury is consistent with person's description of cause

☐ Yes ☐ No ☐ Uncertain

How is the injury related to work or the motor vehicle accident?

Detail any pre-existing factors which may be relevant to this condition or injury(ies)

First name | Last name | Claim number

Management plan for this period

Treatment/medication type and duration

Referral to another health service or rehabilitation provider (include details of provider type and service requested, duration and frequency when relevant)

Capacity for activities – If the person has capacity for pre-injury work this section does not need to be completed. For all others please consider activities of daily living currently being performed.

Lifting/carrying capacity

Sitting tolerance

Standing tolerance

Pushing/pulling ability

Bending/twisting/squatting ability

Driving ability

Other (please specify) eg psychological considerations, keep wound clean and dry

Next review date (DD/MM/YYYY) (if greater than 28 days, please provide clinical reasoning)

Comments

Capacity for work (please consider the health benefits of good work when completing this section).

Where the word 'capacity' appears below it should be read as 'fitness for work' when the certificate is completed in a motor accident injury claim.

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

☐ is fit for pre-injury work from — Date (DD/MM/YYYY)

☐ has capacity for some type of work from ____ to ____ for ____ hours/day ____ days/week

☐ has no current capacity for any work from ____ to ____

If no current capacity for work, estimated time to return to any type of employment

Factors affecting recovery

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First name | Last name | Claim number

Treating medical practitioner details

I certify that I am the treating medical practitioner and I have examined this person. The information and medical opinions contained in this certificate are, to the best of my knowledge, true and correct.

Signature

Date (DD/MM/YYYY)

Name

Address

Suburb

State

Postcode

Telephone number

Provider number

☐ I agree to be the nominated treating doctor for the ongoing management of this person's injury, treatment and recovery at/return to work (tick if you consent).

Section 3: Employment declaration (not to be completed by the treating medical practitioner)

This section is to be completed by the person prior to sending to the insurer (or employer).

First name

Last name

☐ I have ☐ I 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 receive payment in money or otherwise since the last certificate was provided, that I have not yet declared to the insurer.

If so, please provide details below.

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

Signature

Date (DD/MM/YYYY)

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