Medical certificate of capacity - final

Please complete all sections of this form

- *Medical practitioner to retain a copy*
- *This certificate to be given to worker*

Worker details					
Surname:					
Given names:					
Date of birth:	/ /	Date of injury or disease:	/ /		
Gender:	Male ☐	Female ☐	Gender diverse ☐		
Address:					
Suburb:		State:		Postcode:	
Home number:		Work number:			
Mobile number:		Email address:			
Workplace location where injury or disease occurred:					
Employer details					
Employer name:					
Address:					
Suburb:		State:		Postcode:	
Medical assessment					
Date of examination:	/ /	Time of examination:	AM ☐	PM ☐	
Having examined the worker it is my opinion that as from:	/ /				
The worker has ceased to be incapacitated for work					☐
The workers incapacity is no longer a result of the work-related injury / disease					☐
The worker has fully recovered from the work related condition					☐
Grounds for the opinion of medical assessment:					
Medical practitioner details					
Name:		Registration number:			
Address:		Suburb:			
State:		Postcode:		Work number:	
Fax number:		Email address:			
Signature:			Date:	/ /	

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