**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: | | | **/     /** | | | |