**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: | **/     /** |