**This is the approved form for a first certificate of capacity for up to 14 days**

Section 82(1)(b) of the Return to Work Act requires a claim for compensation be accompanied by a medical certificate of capacity in a form approved by the Authority. This form is the approved form for use by a medical practitioner or another person of a class prescribed by regulation that certifies a worker's capacity for work.

* *Medical practitioner to retain a copy*
* *This certificate to be given to worker*
* *Worker to give this certificate to employer with  
  a completed Northern Territory workers compensation claim form*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Worker details** | | | | | | | | | | | | | |
| Surname: |  | | | | | | | | | | | | |
| Given names: |  | | | | | | | | | | | | |
| Date of birth: | **/     /** | | | Occupation: | |  | | | | | | | |
| Gender: | Male |  | Female | |  | Gender diverse | | |  | | | | |
| Address: |  | | | | | | | | | | | | |
| Suburb: |  | | | | | | State: |  | | Postcode: | |  | |
| Home number: |  | | | Work number: | | |  | | | | | | |
| Mobile number: |  | | | Email address: | | |  | | | | | | |
| **Employer details** | | | | | | | | | | | | | |
| Employer name: |  | | | | | | | | | | | | |
| Address: |  | | | | | | | | | | | | |
| Suburb: |  | | | | | | State: |  | | Postcode: | |  | |
| Work number: |  | | | Fax number: | | |  | | | | | | |
| Mobile number: |  | | | Email address: | | |  | | | | | | |
| **Injury details** (from worker) | | | | | | | | | | | | | |
| Date of injury or disease first noticed: | | | | | | | **/     /** | | | | | | |
| Workplace location where injury or disease occurred: | | | | | | |  | | | | | | |
| Workers description of the injury or disease: | | | | | | |  | | | | | | |
| Workers description of how the injury or disease occurred: | | | | | | |  | | | | | | |
| **Medical assessment** (tick only those boxes which apply) | | | | | | | | | | | | | |
| Date of examination: | | | **/     /** | | | | Time of examination: | | | AM |  | PM |  |
| In my opinion the injury or disease is: | | | Consistent with the stated cause | | | | | | | | | |  |
| Inconsistent with the stated cause | | | | | | | | | |  |
| Of uncertain cause (please comment below) | | | | | | | | | |  |
|  | | | | | | | | | | |
| History of current condition: | | |  | | | | | | | | | | |
| Examination: | | |  | | | | | | | | | | |
| Investigations: | | |  | | | | | | | | | | |
| Diagnosis: | | |  | | | | | | | | | | |
| Complications: | | |  | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Fitness for work** (tick only those boxes which apply) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| In my opinion that as from the date of this statement, the worker is: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Fit** to return to ***pre-injury duties, no further treatment*** required. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **Fit** to return to ***pre-injury duties***, but ***requires further treatment*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **Fit** to return to work for restricted hours / days from: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| /     / | | | | to | /     / | | | | | | | | | | (inclusive) | | | | | | | hours per day | | | | | | | | | | | |  | | | | | | hours per week | | | | | | | | | | | | | |  | |
| **Fit** to return to work **on restricted duties** from: | | | | | | | | | | | | | | | | | | /     / | | | | | | | | | | to | | | /     / | | | | | | | | | | | | | | | | (inclusive) | | | | | | | | |
| **Restricted duties:** | | | Avoid prolonged standing / walking / sitting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Avoid squatting / kneeling / ladders / steps | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| No lifting anything heavier than: | | | | | | | | | | | | | | | | | 5kg | | | | | 10kg | | | | | | | | | | | 15kg | | | | | | | | | | 20 kg | | | | | | | | |  |
| Avoid repetitive use of affected body part | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Avoid repetitive bending / lifting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Other (please specify) | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **Totally unfit for work** from: | | | | | | | | | | | | | | | | | | /     / | | | | | | | | | | to | | | /     / | | | | | | | | | | | | | | | | (inclusive) | | | | | | | |  |
| Is this a FIRST and FINAL statement of fitness for work? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | |  | | | | No | | | |  |
| **Injury management** (tick only those boxes which apply) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **1.** | **Medical practitioner / employer contact** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I have made contact with the employer and discussed alternative work options | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| The worker will require more than three days off work, consequently I will be happy to discuss this further with the employer / insurer. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Preferred contact days and time: | | | | | | | Monday | | | | |  | | | | Tuesday | | | | |  | | Wednesday | | | | | | | | | |  | | | | Thursday | | | | | | |  | | | | | | Friday | | | | |  |
| Saturday | | | | |  | | | | Sunday | | | | |  | | Times: | | | | | | AM | | | | | |  | | | | | | | OR | | | | | | PM | | | |  | | | |
| **2.** | **Medical management plan** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Treatment (specify): | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Medication (specify): | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Referred to specialist: (specialty/name): | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Date of appointment: | | | | | | **/     /** | | | | | | | | | | | Time of appointment: | | | | | | | | | | | | |  | | | | | | | | | AM | | | |  | | | | | | PM | | | |  | |  |
| Referred to hospital (specify): | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Referred to Allied Health Professional(s): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Physiotherapist name: | | | | | | | |  | | | | | | | | | | | | | | | | Number of sessions recommended | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Chiropractor name: | | | | | | | |  | | | | | | | | | | | | | | | | Number of sessions recommended | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Other (specify): | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Case conference recommended (specify): | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Vocational rehabilitation referral: | | | | | | | | | | | | | May be necessary | | | | | | | | | | |  | | | | | | | | | | | | | | May not be necessary | | | | | | | | | | | | | | | | |  |
| **3.** | **Review date** | | | | | | | | | | | | Worker to be reviewed on: | | | | | | | | | | | | | | | | | | | | | | | | | **/     /** | | | | | | | | | | | | | | | | | |
| **Medical practitioner details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | | | | | | | | | | | | | | | | | | | | | Registration number: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Address: | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Suburb: | | | | | | | | | | | |  | | | | | | | | | | | | |
| State: | |  | | | | | | | Postcode: | | | | | | | | | |  | | | | | | | | Work number: | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Fax number: | |  | | | | | | | | | | | | | | | | | Email address: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature: | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date: | | | | | | | | | | | | | **/     /** | | | | | | | | | | | |