**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*

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| **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: |  |

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| **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: | **/     /** |