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| Declaration of worker residing outside Australia |
| **Proof of identity and incapacity**. |
| *Regulation 6A pertains to Section 65B(2)(a) of the Return to Work Act and requires a worker to give the employer, at intervals of not less than 3 months, a declaration by the worker and a medical practitioner or, if the worker is living in another country, a person registered under the law of the country that provides for the registration of persons practising the medical profession in a form approved by the Authority. This form is the approved form for the declaration.* |
| **PART 1** |
| **Employer or employer’s insurer details** |
| Name of employer or employer’s insurer: |  |
| Address: |  |
| Suburb: |  | State: |  | Postcode: |  |
| Work number: |  | Email address: |  |
| Claim number: |  |
| **Worker details** |
| Surname: |  |
| Given names: |  |
| Date of birth: | **/     /** | Gender: | Male | [ ]  | Female | [ ]  |
| Residential address: |  |
| Suburb: |  | State: |  | Postcode: |  |
| Postal address: |  |
| Suburb: |  | State: |  | Postcode: |  |
| Phone number: |  | Email address: |  |
| **Declaration of worker** |
| I |  |
| of |  | declare |
| on (date) | **/     /**  | I suffered an injury or disease to my (state part of body affected) |
|  | which happened as follows (describe how it happened) |
|  |
| Before my injury or disease I was working as a (state type of occupation) |  |
| I am currently in paid employment  | Yes | [ ]  | No | [ ]  |
| I have truthfully answered all the questions I have been asked and have fully cooperated to the best of my ability during the course of the medical examination by the doctor identified on page 2 of this declaration. |
| Name (printed): |  | Date: | **/     /** |
| Signature: |  |
| Date that this declaration was forwarded to employer or employer’s insurer: | **/     /** | Posted | [ ]  | Emailed: | [ ]  |
| ***The completed declaration of the worker PART 1 must be sent to the employer or employer’s insurer with the completed declaration of the doctor PART 2***  |
| **PART 2** |
| **Declaration of doctor** |
| Name of doctor: |  |
| Address of doctor: |  |
| Suburb: |  | State: |  | Postcode: |  |
| Postal address: |  |
| Suburb: |  | State: |  | Postcode: |  |
| Phone number: |  | Email address: |  |
| Medical qualifications: |  |
| Date of examination: | **/     /** |
| I declare that I have examined the person named on PART 1 of this declaration and I have confirmed that the person who I examined was that person through the sighting of an official document of the government of this country that contained all the following information about the person: |
| Name | **[ ]**  | Address | **[ ]**  | Date of birth | **[ ]**  | Photograph | **[ ]**  |
| The document I used to confirm identification was (for example a passport): |  |
| The results of my examination of the person named as the worker in PART 1 of this declaration are set out below: |
| 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 prolonged standing / walking / sitting | [ ]  |
| Avoid squatting / kneeling / ladders / steps | [ ]  |
| No lifting anything heavier than: | 5kg | [ ]  | 10kg | [ ]  | 15kg | [ ]  | 20kg | [ ]  | [ ]  |
| Avoid repetitive use of affected body part | [ ]  |
| Avoid repetitive bending / lifting | [ ]  |
| Other (please specify) |  | [ ]  |
| **Totally unfit for work** from: |     /     /      | to |     /     /      | (inclusive) | [ ]  |
| **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): |  |
| Name of doctor (printed): |  | Date: | **/     /** |
| Signature of doctor: |  |
| ***If a worker resides outside Australia, proof of the worker’s identity and incapacity is required every three (3) months***  |