Medical certificate of capacity - first

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:						

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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:	/ /	