Medical certificate of capacity - progress

Recommended for a maximum 28 days duration

Note: maximum referral period for rehabilitation treatment prior to review is initially 14 days, and then 28 days subsequent referrals to the same discipline.

- *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:			
Employer details					
Employer name:					
Address:					
Suburb:		State:		Postcode:	
Medical assessment					
Date of examination:	/ /	Time of examination:	AM ☐	PM ☐	
Clinical findings / diagnosis at this examination:					

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 <u>**on restricted duties**</u> 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)					
I will review the worker (date of next appointment):	/ /					

NT WorkSafe

NORTHERN TERRITORY GOVERNMENT

Injury management (tick only those boxes which apply)										
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				
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):										
Vocational rehabilitation – options must be discussed with the worker										
Likely to be necessary, subject to review in		weeks								☐
I would like the employer / insurer to organise a referral and discuss with me.										☐
Preferred contact days and time:	Monday	☐	Tuesday	☐	Wednesday	☐	Thursday	☐	Friday	☐
	Saturday	☐	Sunday	☐	Times:	AM OR PM				
Vocational rehabilitation referral:	May be necessary	☐	May not be necessary	☐						

Medical practitioner details			
Name:		Registration number:	
Address:		Suburb:	
State:		Postcode:	
Work number:		Fax number:	
Email address:			
Signature:		Date:	/ /