

## Medical certificate of capacity for work

## Part A – Provides a medical assessment of your work capacity

First name	Last name Date of birth		e of birth		
Current occupation		Date	e assessed		
Clinical symptoms/dia	gnosis				
Comments on physical capacity					
Comments on mental capacity					
Comments on other issues impacting recovery or return to work					
I recommend that:	you are fit for work from	n to			
	you are fit for work from	n to	with the following:		
graduated return to work					
modified duties					
reduced hours					
workplace adjustment					
return to work place (attached)					
	you are <b>not fit for work</b>	from to			
Reason unfit for work:					
I recommend the following medical management and/or work rehabilitation:					
	ations, investigation eferral	Purpose	Frequency		

Next review date						
Clinical reasoning (if > 28 days	s):					
Part B – Provides additional information for your insurer, if the certificate						
relates to a claim for co	•					
Claim number	First seen in relation to this condition at this practice on					
Date injury was sustained/disease was contracted / /						
Based on the information available to me, this was caused by						
<del></del>		ar e sa su				
The injury/disease is	he injury/disease is an aggravation of a pre-existing condition					
a continuing injury/disease						
	a new inju	ry/disease				
Factors which may be relevant to the condition or recovery (if any) are:						
To assist recovery and return t	o work I request	a return to work case confere	ence with the employer			
and employee Yes N	No					
This certificate is an initi	ial certificate	a continuing certificate	a final certificate			
Part C – Medical practitioner's details						
Please affix practice stamp here or provide contact details and provider number.						
<b>1</b>						
Medical practitioner's signat	iure					
		Date				