Workers Compensation Certificate of Capacity

Tasmania

- This certificate is to be used to support a claim for workers compensation under the *Workers Rehabilitation and Compensation Act 1988*.
- This certificate is to be completed by the medical practitioner and issued to the worker.
- Medical practitioners should detail the worker's injury and capacity to perform functional tasks, and are encouraged to focus on capacity rather than incapacity.
- This information will be used to assess and manage the worker's claim for workers compensation including finding suitable alternative duties based on the worker's job and functional capacity.
- **For guidance on completing this certificate access the How to Guide: Workers Compensation Certificate of Capacity from www.worksafe.tas.gov.au.**

1. Worker details

Given name(s):

Surname: Date of birth: / /

Address:

Suburb: State: Postcode:

Employer:

2. Injury details and assessment

What type of Workers Compensation Certificate of Capacity is this? Initial ◯ Subsequent ◯

Date of injury or when the worker became totally or partially incapacitated, that is, unable to do some or all of their job: * / /

Stated cause: *

Is the injury consistent with the worker's description of cause? * Yes ◯ No ◯

The injury is: * ◯ A new injury ◯ A recurrence, aggravation, acceleration, exacerbation or deterioration of any pre-existing injury or disease. Provide details:

* *Only mandatory if this is an initial certificate.*

Consultation date: / /

Current symptoms:

Current clinical diagnosis/diagnoses:

Has the diagnosis changed since the last certificate? Yes ◯ No ◯ N/A ◯

Does the diagnosis include a secondary injury as a result of the initial compensable injury? Yes ◯ No ◯

eg. mental health injury as a result of a physical injury.

Provide details:

3. Injury management/treatment

Treatment and services
Include injury management strategies to increase capacity for work and/or address return to work barriers:

List any medications prescribed for the injury related to this claim:

Referral
Indicate any referrals you have made for the worker relevant to this review.

Name: Speciality/Service:
I have referred the worker for the following:

Name: Speciality/Service:
I have referred the worker for the following:

Name: Speciality/Service:
I have referred the worker for the following:

4. Capacity assessment

Physical function (if applicable)
Select the applicable option for every function listed.

	can	with modifications	cannot		can	with modifications	cannot
Sit	○	○	○	Stairs/climbing	○	○	○
Stand/walk	○	○	○	Neck movement	○	○	○
Bend	○	○	○	Reach above shoulder	○	○	○
Squat	○	○	○	Use affected body part	○	○	○
Kneel	○	○	○	Drive regular vehicles	○	○	○
Lift	○	○	○	Drive/operate heavy machinery	○	○	○

Physical function comments: referring to the selections above, detail what the worker can and cannot do at work that will assist in identifying suitable duties. *eg. Lift: Cannot lift greater than 5kg above shoulder height, Bend: Cannot bend below waist height.*

Psychosocial function (if applicable)
Select the applicable option for every function listed.

	can	with modifications	cannot		can	with modifications	cannot
Interact and communicate with people	◯	◯	◯	Initiate and complete tasks/ maintain energy levels	◯	◯	◯
Maintain attention/concentration	◯	◯	◯	Recall information (short/long term memory)	◯	◯	◯
Adapt and respond to stressful, unpredictable, or changing circumstances	◯	◯	◯	Make decisions	◯	◯	◯

Psychosocial function comments: referring to the selections above, detail what the worker can and cannot do at work that will assist in identifying suitable duties. *eg. Interact with people: Cannot serve customers but can interact with team members, Energy levels: Requires self-paced work.*

Other factors affecting capacity *eg. effects of medication.*

5. Certification of capacity

Taking into account the capacity assessment in section 4, the worker:
Select and complete any of the options below that apply to the worker (you may select one or multiple options if applicable).

◯ **Is fit for pre-injury work from:** ☐☐ / ☐☐ / ☐☐☐☐

◯ **Has capacity for pre-injury work with restrictions/modifications from:**

☐☐ / ☐☐ / ☐☐☐☐ to ☐☐ / ☐☐ / ☐☐☐☐ Capacity for work (days/hours per week):

Comments about restrictions and modifications required to the worker's pre-injury duties. This might include graduated return-to-work hours/days for the certification period, factors affecting recovery, rest breaks, and reasonable adjustments required to facilitate recovery and return to work:

◯ **Has capacity for suitable alternative work from:**

☐☐ / ☐☐ / ☐☐☐☐ to ☐☐ / ☐☐ / ☐☐☐☐ Capacity for work (days/hours per week):

Comments that will help the workplace identify suitable alternative work. This might include suitable tasks, graduated return-to-work hours/days for the certification period, rest breaks, factors affecting recovery and reasonable adjustments required to facilitate recovery and return to work:

◯ Requires permanent alternative work from: ☐☐ / ☐☐ / ☐☐☐☐

◯ **Has no current capacity for any work from:** ☐☐ / ☐☐ / ☐☐☐☐ to ☐☐ / ☐☐ / ☐☐☐☐

Estimated time to return to any work: ☐☐ days or ☐☐ weeks.

If more than 28 days of total incapacity, then you must provide a reason and a review date.

Reason:

Review Date: ☐☐ / ☐☐ / ☐☐☐☐

Review
Choose one of the options below.

◯ The worker requires further review by me.

Review date: ☐☐ / ☐☐ / ☐☐☐☐

◯ The worker does not require further review by me but requires ongoing treatment.
Provide details:

◯ The worker requires no further review or treatment.

I have discussed the different types of activities and functions the worker may (or may not) be able to perform in the workplace *(select all that are applicable):*

◯ With the worker

◯ With the worker's workplace

◯ With the worker's rehabilitation provider or injury management coordinator

6. Certifier declaration

I certify that I have undertaken a consultation with the worker. The clinical opinions I have provided in this certificate are, to the best of my knowledge, true and correct.

Provider details (or practice stamp):

Signature of certifier:

Provider number:

Name of certifier:

Date of issue: ☐☐ / ☐☐ / ☐☐☐☐

For more information contact:
WorkSafe Tasmania
Phone: 1300 366 322 (within Tasmania)
(03) 6166 4600 (outside Tasmania)
Email: wstinfo@justice.tas.gov.au

Published October 2023 V1.4