Workers Compensation and Injury Management Act 2023

Non-Resident worker — incapacity declaration

## To

|  |  |
| --- | --- |
| Insurer: |   |

## Part 1

## Worker

|  |  |
| --- | --- |
| Name: |   |
| Address: |   |
| Date of birth: |   |
| Phone number: |   |
| Email address: |   |

## Employer

|  |  |
| --- | --- |
| Name: |   |
| Address: |   |

## Claim

|  |  |
| --- | --- |
| Insurer claim number: |   |

## Declaration

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 medical practitioner named in PART 2 of this declaration.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed:** |  | Date: |  |

(Signed by worker)

## PART 2

## Medical practitioner declaration

|  |
| --- |
| I declare that I have examined the person named in 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 the country in which the person resides. |
| The following document(s) was used to confirm identification of the person: |
|  |
| Date of assessment: |   |

## Medical Management

|  |  |
| --- | --- |
| Clinical findings/ diagnosis: |   |
| Medication: |   |
| Imaging: |   |
| Referral to specialist/ hospital: |   |
| Approved health treatment: |   |

## Work Capacity

|  |  |
| --- | --- |
| Worker’s usual duties  |   |
| I find this worker to have: |
| [ ]  | **Full capacity** for work, from: |   | [ ]  Requires further treatment |
| [ ]  | **Some capacity** for work, from: |   | to: |   |
|  |

|  |  |  |
| --- | --- | --- |
| [ ]  Pre-injury duties | [ ]  Modified or alternative duties | [ ]  Workplace modifications |
| [ ]  Pre-injury hours | [ ]  Modified hours of |  | hrs/day, |  | days/week |

 |
| [ ]  | **No capacity** for work, from: |   | to: |   |
| Work restrictions(Where no capacity for work, provide clinical reasoning) |
|  |
|  |
|  |

## Medical practitioner

|  |  |
| --- | --- |
| Name: |   |
| Address: |   |
| Registration number: |   |
| Medical speciality: |   |
| Phone number: |   |
| Email address: |   |
| **Signed:** |  | Date: |  |