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: |  |