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Workers Compensation and Injury Management Act 2023

APPROVED FORM [s. 496]

Non-Resident Worker – Incapacity Declaration

In accordance with section 496 of the *Workers Compensation and Injury Management Act 2023* the approved form for the required declarations to be provided by a worker for the purposes of section 65(1) of the Act is **Non-Resident Worker – Incapacity Declaration** in Appendix 1.

Non-Resident Worker – Incapacity Declaration in Appendix 1 is effective 1 July 2024 and registered as WorkCover WA Approved Form CN5 – v1 [D2024/36867].

CHRIS WHITE
CHIEF EXECUTIVE OFFICER

26 March 2024

Appendix 1

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)

Appendix 1

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)

.....

.....

.....

Appendix 1

Medical practitioner

Name: .....

Address: .....

Registration number: .....

Medical speciality: .....

Phone number: .....

Email address: .....

Signed: ..... Date: .....