GOVERNMENT OF WESTERN AUSTRALIA | WorkCoverWA

Workers Compensation and Injury Management Act 2023

FINAL certificate of capacity

1. WORKER'S DETAILS

First name		Last name	
Date of birth		Claim no.	
Phone		Email	
Address			

2. EMPLOYER'S DETAILS

Employer's name		Employer's phone	
Employer's address			

3. MEDICAL ASSESSMENT

Date of this assessment | Date of injury

☐ The worker's condition is unlikely to change substantially in the next 12 months

4. WORK CAPACITY

Having considered the health benefits of work, I find this worker to have:

☐ **full capacity for work** from ☐ but requires further treatment *(outline specifics below)*

☐ **capacity for work** performing ☐ hours per day and ☐ days per week from

as outlined below: *(Please outline the worker's physical and/or psychosocial capacity for work, functional limits, ongoing need for workplace modifications, and/or further treatment needs)*

☐ lift up to ☐ kg
☐ sit up to ☐ mins
☐ stand up to ☐ mins
☐ walk up to ☐ m
☐ work below shoulder height

☐ **The worker's incapacity is no longer a result of the injury**

5. REASON FOR CAPACITY/INCAPACITY

Please outline your clinical reason for the worker's capacity/incapacity:

6. MEDICAL PRACTITIONER'S DETAILS

Name		AHPRA no. MED	
Address		Email	
		Signature	
Phone			
Fax		Date	