Workers Compensation and Injury Management Act 2023

PROGRESS 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	
Diagnosis			

4. PROGRESS REPORT

Activities/interventions	Actual outcome *(change in symptoms, function, activity and work participation)*	Still required?*	
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No

**(If management activities/interventions are still required, please also list them in Section 6 'Injury Management Plan')*

☐ Other factors appear to be impacting recovery and return to work

Comment

5. WORK CAPACITY

Worker's usual duties

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

☐ **full capacity for work** from ☐ but requires further treatment

☐ **some capacity for work**, from to performing:

☐ pre-injury duties ☐ modified or alternative duties ☐ workplace modifications

☐ pre-injury hours ☐ modified hours of hrs/day days/wk

☐ **no capacity for any work** from to *(outline clinical reason on next page)*

5. WORK CAPACITY (CONTINUED)

Worker has capacity to:

(Please outline the worker's physical and/or psychosocial capacity – refer to explanatory notes for examples. Where there is no capacity for work, please provide clinical reasoning.)

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

6. INJURY MANAGEMENT PLAN

Activities/interventions	Purpose/goal *(likely change in symptoms, function, activity and work participation)*

☐ I support the RTW program established by the employer/insurer/WRP dated

☐ I would like more information about available duties

☐ I would like to be involved in developing the RTW program

☐ Please engage a workplace rehabilitation provider *(If you have made a referral, provide name and contact details below)*

Examples of injury management activities/interventions include:

- *further assessment - diagnostic imaging, medical specialist consults, worksite assessment*
- *intervention - physiotherapy, clinical psychology, exercise physiology, prescribed medications, workplace mediation*
- *return to work planning - identify suitable duties, establish return to work program*

7. NEXT REVIEW DATE

☐ I will review worker again on *(if greater than 28 days, please provide clinical reasoning)*

Comments

8. MEDICAL PRACTITIONER'S DETAILS

Name

Address

Phone

Fax

(Practice stamp – optional)

AHPRA no. MED

Email

Signature

Date