

**WORKERS COMPENSATION
MEDICAL CERTIFICATE**

CONTINUING/FINAL

CONTINUING/FINAL CERTIFICATE SECTION BY SECTION

The medical practitioner usually has continued contact with the injured worker throughout the injury management process; provides important information (such as certification of incapacity, work restrictions, diagnosis, treatment); and can play a key role in the cooperation between the injured worker, the employer and the insurer.

A medical practitioner's responsibilities include:

- completing workers compensation medical certificates
- providing diagnosis, primary care and coordination of medical treatment (including referral to and coordination of specialist care as appropriate)
- monitoring, reviewing and advising on the injured worker's condition and treatment
- specifying work restrictions and advising on suitability of duties offered by the employer
- participating in the development of Injury Management Plans and Return to Work Plans.

This certificate has been designed to establish a worker's capacity for work, expedite their return to work, and reduce the need for the insurer or employer to request medical reports.

SECTION 1 – CONTINUING/FINAL MEDICAL CERTIFICATE COMPLETION

Under Section 69(1) of the *Workers Rehabilitation and Compensation Act 1988* a continuing/final medical certificate supports an ongoing entitlement to workers compensation. A continuing/final certificate should ONLY be completed upon visits **SUBSEQUENT** to the worker's initial consultation.

SECTIONS 2 TO 4 are self explanatory.

SECTION 5 – WORKPLACE CONTACT

Workplace contact initiated by the medical practitioner is encouraged. Contact with an employer can greatly improve the worker's return to work outcome, primarily through the identification of available suitable duties that may have otherwise resulted in certification of total incapacity.

SECTION 6 – CAPACITY TO WORK

Where the worker is incapacitated for any work, that is, unable to do work of any kind, certification should only be granted up to a maximum of 14 days. In circumstances where certification for more than 14 days is required, the medical practitioner must provide reasons to substantiate the decision, together with an appointed review date (Section 8).

Suitable Duties

Where the worker is assessed as partially incapacitated, legislation requires that the employer provides suitable duties.

Suitable duties may include:

- changes or restrictions to a worker's pre-injury duties to allow them to return to work and/or
- different duties from those performed by the worker prior to the injury or disease.

SECTION 7 – RETURN TO WORK

This section is designed to assist the employer in the planning of return to work processes by ensuring that any duties identified are consistent with medical opinion and are not detrimental to the worker's recovery.

Restrictions

When a worker is deemed fit to return to suitable duties, restrictions assist to outline any limitations and/or accommodation issues that exist upon the worker's return to work. Restrictions safeguard the worker and ensure that planned return to work processes are appropriate and do not put the worker at risk of re-injury.

In circumstances where restrictions are more complex, it is advisable that the medical practitioner contacts the employer to provide a comprehensive explanation of the worker's functional capacity so that it is clearly understood.

Details of any permanent restrictions that may have resulted are also to be included.

SECTION 8 – MEDICAL MANAGEMENT

To assist in the management of the worker's injury, details concerning proposed treatment (including referral to other service providers) are to be supplied, including the name of the service provider as well as the type of service that is to be provided.

It is important that medical information is shared between treating providers, no matter what their level of involvement, to ensure they are fully aware of all the medical information important to the worker's medical management.

The last part of this section is completed to indicate when, or if, the worker's condition needs to be reviewed.

SECTION 9 – SIGNATURES

The worker is asked to give their consent for the medical practitioner to contact the employer and to the dissemination of information on the claim form. This allows the employer and the insurer to gather relevant information on the claim.

The certificate should carry the date that it is actually signed by the worker and the medical practitioner, even if the visit was on another day (that will be indicated by the date of examination in Section 4).

For the purpose of this form:

- reference to an '**accredited medical practitioner**' includes a '**medical practitioner**' as defined under the *Workers Rehabilitation and Compensation Act 1988*; and
- reference to a '**medical practitioner**' includes a '**primary treating medical practitioner**' as defined under the *Workers Rehabilitation and Compensation Act 1988*.

Please note: Incomplete certificates can result in a worker's claim being rejected or deferred and consequently may cause considerable financial hardship to the worker due to delays in payment of benefits.

Black – Insurer's copy
Brown – Worker's copy
Green – Doctor's copy

CONTINUING/FINAL Workers Compensation Medical Certificate

Section 69(1) of the Workers Rehabilitation and Compensation Act 1988



1. Continuing/Final Medical Certificate Completion

This form is to be completed for all visits subsequent to an initial consultation

If it is the patient's FIRST consultation an INITIAL Workers Compensation Medical Certificate must be completed

All sections of this form must be completed unless stated otherwise

2. Worker's Name

3. Employer's Name

4. Medical Assessment

I examined the above worker on

Current symptoms:

Current diagnosis:

Has the diagnosis changed? YES NO

If yes provide details:

5. Workplace Contact

Has the workplace/employer been contacted to discuss management and/or restrictions?

YES NO

Workplace Contact Date

6. Capacity to Work

Prior to determining work capacity it is recommended that the worker's employer/workplace is contacted (refer above)

Note: Capacity is determined by the medical practitioner's assessment not by the availability of work in the workplace

I consider the worker:

Requires further treatment but is fit for pre-injury duties (proceed to 8)

Is fit for suitable duties (Refer to explanatory notes on cover for definition)

from to

(proceed to 7)

Will be incapacitated for any work

from to

If greater than 14 days give reasons together with an appointed review date at Section 8:

Will cease to be incapacitated for work on (proceed to 9)

Is fit for ongoing suitable duties from

Are duties permanent? YES NO (proceed to 7)

7. Return to Work

Full-time YES NO

Graduated YES NO

(insert week) Week to Week Week to Week

Hours/Day

Days/Week

7. Return to Work Continued

Are rest breaks required?

YES mins every hr(s) NO

Please indicate areas of reduced capacity:

Use arm(s) YES NO

Elevate arm(s) YES NO

Lift weight YES NO

Bend/squat/twist YES NO

Pull/push YES NO

Climb YES NO

Sit YES NO

Stand YES NO

Drive/operate machinery YES NO

Use public transport YES NO

Other YES NO

Comments: (if YES comment on restrictions e.g. capacity for repetitive actions)

Are there any other impediments to return to work?

(eg: psychological, external factors or assistance to be provided)

YES Details:

NO

8. Medical Management

Has the worker consulted any other health professionals regarding these symptoms?

YES Details:

NO

Treatment/medication/investigations:

I have referred the worker to (usual GP/other health professionals)

Name of provider:

Details:

Is any procedure likely?

YES Details:

NO Date procedure scheduled

I wish to review the worker

YES On

NO Medical treatment has ceased and no further intervention is required (final consultation)

9. Signatures

Worker's consent to contact and discuss matters in this certificate with employer, including any agent of the employer:

Signature:

Date

WorkCover Accredited Medical Practitioner

Signature:

Date

10. WorkCover Accredited Medical Practitioner Details

Name:

Address:

Phone: Fax:

GP/Specialty: Provider No:

PLEASE PRINT