

Medical Certificate

For ACT Workers Compensation Claims - to be completed by a Doctor

AF2004-3
Workers Compensation Act 1951 – Form 1

Injured person's surname/family name
Given Names
Date of birth

Medical Information

Date of injury
Date of initial assessment

Please complete the following four categories, with reference to clinical examination, any investigations, and approved medical guidelines or clinically relevant research.

Description of Injury/Aetiology

Is the injury/disease consistent with the aetiology described by the patient? Yes/No

Diagnosis

Prognosis

Treatment

Note: If this is not the first certificate it is not necessary to complete the above four categories, unless any change has taken place. If there is any change in the four categories in relation to the patient, please state the changes with reference to approved medical guidelines, clinically relevant research and examination or investigations.

Does the aetiology or diagnosis suggest a pre-existing condition or aggravation of pre-existing condition? Yes/No

The question below only needs to be answered where a disease is the cause of a claim for compensation for an injury.

Do you consider the workers injury is consistent with their employment being or having been a substantial contributing factor to the injury? Yes/No

Proposed treatment plan

Treatment likely to be required: **Nil/Short Term (< 6 weeks)/Medium Term (6-12 weeks)/Long Term (>12 weeks)**

Referred to Specialist	Type	Name of person	Phone/contact details
Referred to Therapy	Type	Name of person	Phone/contact details
Referred to Other	Type	Name of person	Phone/contact details

Will the patient be incapacitated for work for a continuous period of longer than 7 days?

If 'Yes' a rehabilitation service will automatically be provided for the patient.

Please indicate the patient's fitness for work.

Fit to resume normal duties on
Unfit for work from

Fit for modified or other duties on
Date of Next medical assessment

Medical Practitioner's Information

Name (please print)
Professional qualification
Provider number

Practice / Hospital Name and address/
Telephone number

I declare that: I am registered medical practitioner; to the best of my knowledge the information provided here is true and correct; and I am prepared to be my patient's treating doctor for the purposes of the Workers Compensation Act 1951.

Signature Date

Approved by the Minister for Industrial Relations on 27 April 2004 under the Workers Compensation Act 1951, s. 223.

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