Form

Statement of fitness for work – First certificate

This is the approved form for a first statement of fitness for work up to 14 days

Section 82(1)(b) of the *Return to Work Act* requires a claim for compensation be accompanied by a statement of fitness for work in a form approved by the Authority. This form is the approved form for use by a medical practitioner or another person of a class prescribed by regulation that certifies a worker's capacity for work.

- *Medical practitioner to retain a copy*
- *This statement to be given to worker*
- *Worker to give this statement to employer with a completed Northern Territory workers compensation claim form*

Worker details						
Surname:						
Given names:						
Date of birth:	/ /	Gender:	Male ☐ Female ☐	Occupation:		
Address:						
Suburb:		State:		Postcode:		
Home number:		Work number:				
Mobile number:		Email address:				

Employer details						
Employer name:						
Address:						
Suburb:		State:		Postcode:		
Work number:		Fax number:				
Mobile number:		Email address:				

Injury details (from worker)	
Date of injury or disease first noticed:	/ /
Workplace location where injury or disease occurred:	
Workers description of the injury or disease:	
Workers description of how the injury or disease occurred:	

Medical assessment (tick only those boxes which apply)				
Date of examination:	/ /	Time of examination:	AM ☐ PM ☐	
In my opinion the injury or disease is:	Consistent with the stated cause			☐
	Inconsistent with the stated cause			☐
	Of uncertain cause (please comment below)			☐
History of current condition:				
Examination:				
Investigations:				
Diagnosis:				
Complications:				

Fitness for work (tick only those boxes which apply)						
In my opinion that as from the date of this statement, the worker is:						
Fit to return to ***pre-injury duties, no further treatment*** required.						☐
Fit to return to ***pre-injury duties***, but ***requires further treatment***						☐
Fit to return to work for restricted hours / days from:						☐
/ /	to / / (inclusive)		hours per day		hours per week	
Fit to return to work **on restricted duties** from:	/ / to / / (inclusive)					
Restricted duties:	Avoid prolonged standing / walking / sitting					☐
	Avoid squatting / kneeling / ladders / steps					☐
	No lifting anything heavier than:	5kg ☐	10kg ☐	15kg ☐	20kg ☐	☐
	Avoid repetitive use of affected body part					☐
	Avoid repetitive bending / lifting					☐
	Other (please specify)					☐
Totally unfit for work from:	/ / to / / (inclusive)					☐
Is this a FIRST and FINAL statement of fitness for work?	Yes ☐ No ☐					

Injury management (tick only those boxes which apply)					
1. Medical practitioner / employer contact					
I have made contact with the employer and discussed alternative work options					☐
The worker will require more than three days off work, consequently I will be happy to discuss this further with the employer / insurer.					☐
Preferred contact days and time:	Monday ☐	Tuesday ☐	Wednesday ☐	Thursday ☐	Friday ☐
	Saturday ☐	Sunday ☐	Times: AM	OR PM	
2. Medical management plan					
Treatment (specify):					☐
Medication (specify):					☐
Referred to specialist: (specialty/name):					☐
Date of appointment: / /	Time of appointment;		AM ☐ PM ☐		
Referred to hospital (specify):					☐
Referred to Allied Health Professional(s):					
Physiotherapist name:		Number of sessions recommended			
Chiropractor name:		Number of sessions recommended			
Other (specify):					
Case conference recommended (specify):					☐
Vocational rehabilitation referral:	May be necessary ☐		May not be necessary ☐		
3. Review date	Worker to be reviewed on: / /				

Medical practitioner details					
Name:			Registration number:		
Address:			Suburb:		
State:		Postcode:		Work number:	
Fax number:		Email address:			
Signature:			Date:	/ /	