FORM 3

Workers' Compensation and Injury Management Act 1981

(Sections 57A(1)(b), 57B(1)(b) & 61(1) and 231(1)(b))

Workers' Compensation FIRST Medical Certificate

1. Worker's Details

First name(s): .....Surname:.....

Address: .....

Telephone: 08..... Date of birth: .....Occupation: .....

☐ I have provided a WorkCover WA Injury Management brochure to the worker.

2. Employer Details

Name & address of worker's employer: .....

.....

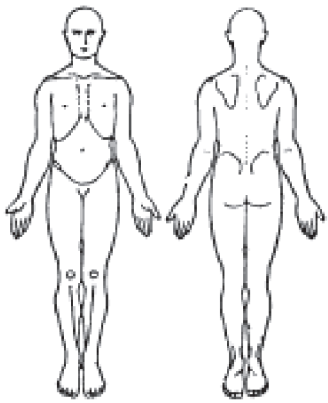
3. Consent Authority *(to be signed at the option of the worker)*

I authorise any doctor who treats me (whether named in this certificate or not) to discuss my medical condition, in relation to my claim for workers' compensation and return to work options, with my employer and with their insurer.

Worker's Signature:.....Date:.....

IMPORTANT: FAILURE TO PROVIDE YOUR SIGNATURE ON THE AUTHORITY ABOVE MAY DELAY A DECISION BY YOUR EMPLOYER ON YOUR CLAIM.

AFFECTED AREA



4. Details from Worker

Date of injury: .....

Workplace location where incident occurred: .....

Worker's description of the injury: .....

.....

Worker's description of how the injury occurred:.....

.....

5. Medical Assessment

Clinical findings / diagnosis *(include possible complications, effect of prior injury or medical condition)*:

.....

.....

.....

In my opinion the above diagnosis ☐ **does** / **does not** ☐ correlate with the injury described to me by the worker.

INJURY MANAGEMENT

6. Fitness for Work It is my opinion that as from the date of this certificate the worker is:

☐ First and FINAL certificate
[See reg. 7 and s. 61(1) of the Act]

FIT

☐ Fit to return to pre-injury duties, no further treatment required.

☐ Fit to return to pre-injury duties, but requires further treatment.

☐ Fit for restricted return to work from:..... to .....

- ☐ restricted hours *(please specify)*:.....
- ☐ restricted days *(please specify)*: .....
- ☐ restricted duties.

☐ Work restrictions:

- ☐ No lifting anything heavier than _____ kg.
- ☐ Avoid repetitive bending / lifting.
- ☐ Avoid repetitive use of affected body part:.....
- ☐ Avoid prolonged standing / walking / sitting.
- ☐ Keep injured area clean & dry.

Other restrictions:.....

.....

.....

.....

.....

☐ **UNFIT** Totally unfit for work for ..... days from ..... to ..... *(inclusive)*.

7. Medical Management

☐ Medication: .....

☐ Approved allied health treatments *(specify type and include number of sessions recommended)*: ..... ☐ Imaging: .....

☐ Referred to hospital/specialist *(name)*: .....

Other treatment: .....

.....

Next appointment *(Unless "First & Final Certificate")* Date ..... Time.....

If the worker is reviewed within 14 days, the worker cannot be required, under section 64 or 65 of the Act, to submit to a medical examination by a medical practitioner provided by the employer, on a day chosen by the employer that is within one month of the date of this certificate.

8. Medical Practitioner / Employer Contact

☐ I have made contact with the employer and discussed alternative work options.

☐ The worker will be off work for more than **3 working days and/or is unable to return to normal duties. Employer please fax your contact details** as I will contact you to discuss return to work options.

☐ The worker is able to return to normal duties. Contact with employer not necessary at this stage.

9. Medical Practitioner's Details

Name:..... Registration No: .....

Address: .....

Telephone:.....Fax: .....

Time & Date of examination: .....Signature:.....

For workers' compensation and injury management information or assistance contact WorkCover WA's Infoline: 1300 794 744