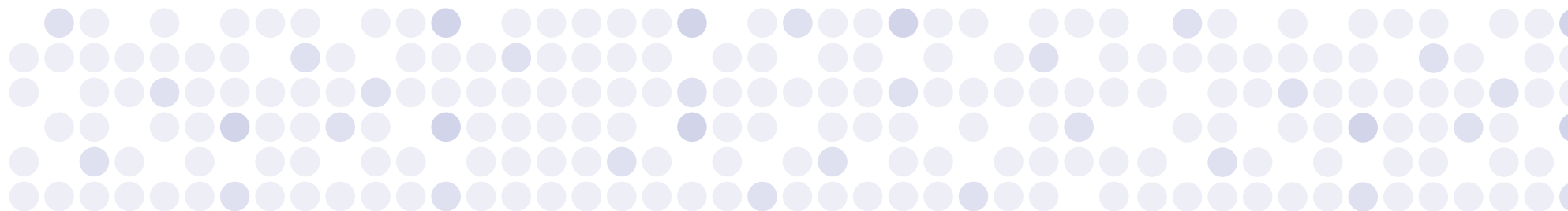
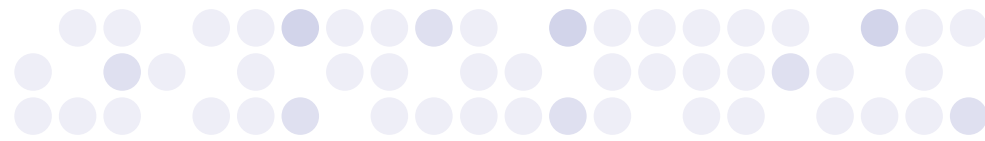


# Understanding the workers' compensation medical certificate

Information for rehabilitation and return to work coordinators and their employers

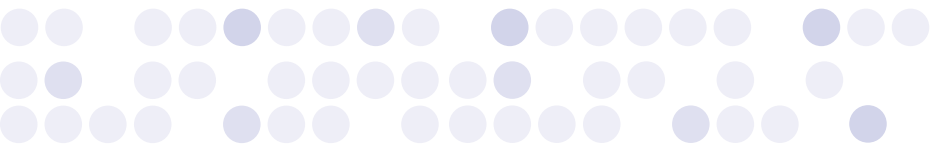


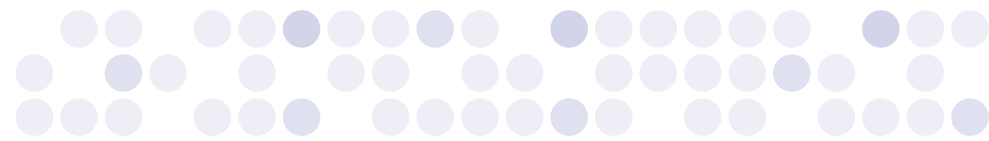


# Contents

---

Background	3
A practical example	4
Sample medical certificate	5
Part A explained	6
Parts B, C and D explained	7
Parts E and F explained	8
Sample suitable duties program	9





# Background

## What is a workers' compensation medical certificate?

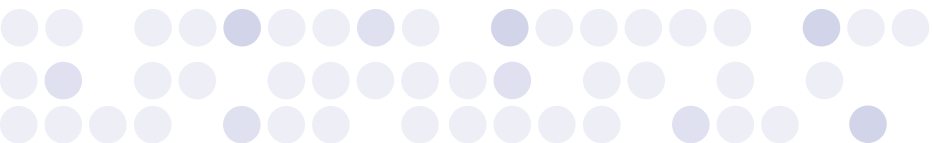
The workers' compensation medical certificate is a legal document that can only be completed by a registered doctor or dentist. Injured workers who wish to lodge a claim for a work related injury must provide the insurer with a completed certificate as part of the application process.

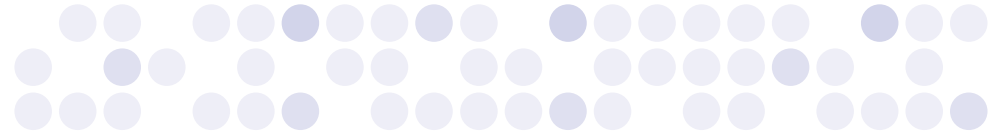
This tool is designed to help you understand the workers' compensation medical certificate and provide guidance on how it should be used when developing suitable duties programs for your injured workers.

## What is it used for?

The workers' compensation medical certificate is used by doctors as a major form of communication between them and the injured worker, the insurer, the worker's employer, the rehabilitation and return to work coordinator and any other treatment providers.

The certificate sets out the treating doctor's recommendations for return to work to insurers and employers. For this reason it's important that you follow these recommendations when developing suitable duties programs so that the worker can make a safe return to work. If you believe there is sufficient information on the workers' compensation medical certificate or in a report which has been provided by the treating doctor, you are not required to ask them to sign the worker's suitable duties program.





## A practical example

Page 5 provides you with an example of a completed workers' compensation medical certificate for John Smith, a carpenter who injured his back at work. At the time of the injury John was employed by Sky High Constructions.

Following the accident, John attends an examination with his treating doctor, Dr Peter Jones. During the appointment, Dr Jones completes the medical certificate, keeps one for himself and gives the other three copies to John. John keeps his copy, sends the insurer copy to WorkCover Queensland and gives the employer copy to his rehabilitation and return to work coordinator.

Sky High Constructions' rehabilitation and return to work coordinator is able to develop a suitable duties program for John based on the information provided in Parts A & E of this medical certificate.

Dr Jones has given approval for John to commence a suitable duties program on 2 February 2009 and will review his progress on 13 February 2009.

John's restrictions are:

- occasional lifting up to 5kg
- no bending, twisting or squatting
- alternate sitting & standing (sitting for a maximum period of 30 minutes).

John can commence working 4 hours per day during the first week of his suitable duties program and increase his hours during week 2 as tolerated.



# Sample medical certificate

## Workers' compensation medical certificate

### CLAIM ENQUIRIES

WorkCover Queensland 1300 362 128  
Self insurance or other enquiries 1300 361 235

86.R

PARTS A AND F OF THIS MEDICAL CERTIFICATE COMPRISE AN APPROVED FORM UNDER THE WORKERS' COMPENSATION AND REHABILITATION ACT 2003

Tick  if applicable, and fill in the information as requested.

New claim  On-going claim Claim number: \_\_\_\_\_

### PART A

#### Injured worker details

I certify that on 28 / 01 / 09 I attended (given names) John

(surname) Smith (DOB) 17 / 03 / 64

Workers daytime contact phone number 07 3421 1234

Worker's employer name Sky High Constructions

He/she was/is suffering from (list all medical/dental diagnoses relevant to the claim):

Diagnosis: L5/S1 disc protrusion

This is a provisional diagnosis (if provisional complete Part C)

Worker was first seen at this practice/hospital for this injury/disease on 22 / 12 / 08

Worker stated date of injury 21 / 12 / 08

Worker's stated cause of injury (if not previously supplied): Lifting at work

Injury/disease is consistent with worker's description of cause:  Yes  Uncertain

Pre-existing factors relevant to the diagnosis (if not previously supplied): None

#### Worker's capacity for work

Fit to return to normal duties from \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Fit for suitable duties (restricted return to work) from 02 / 02 / 09 to 13 / 02 / 09  
(complete Part E)

Not able to work at all from 28 / 01 / 09 to 01 / 02 / 09  
(complete Part D)

Estimated time to return to normal work duties: \_\_\_\_ days/weeks/months  Unknown

(if greater than 10 days or unknown complete Part D)

#### Medical management

Worker will require treatment from 28 / 01 / 09 to 13 / 02 / 09 (complete Part D)

Worker will be reviewed again on 13 / 02 / 09

Worker does not need further review

### PART B

#### Further information

Details of findings/clinical notes relevant to the condition: \_\_\_\_\_

I would like the insurer to contact me upon receipt of this certificate

Preferred method of contact:

Phone: day(s)/time(s) \_\_\_\_\_  Fax  Email

This form was approved by the Chief Executive Officer of Q-COMP, the Workers' Compensation Regulatory Authority, on 23 January 2009, pursuant to section 586 of the Workers' Compensation and Rehabilitation Act 2003. PRIVACY STATEMENT – Under the Workers' Compensation and Rehabilitation Act 2003 and earlier Queensland workers' compensation legislation, the workers' compensation insurer is authorised to collect the information on this form to process the claimant's application for compensation.

Some or all of the information contained in this form may be disclosed to the claimant's employer, another insurer, medical or allied health providers or any other workers' compensation authority in any jurisdiction.

### PART C

#### Diagnostic plan (complete if provisional diagnosis indicated at Part A)

I have ordered:  Diagnostic imaging  Pathology  Other investigations

Details: \_\_\_\_\_

### PART D

#### Medical management plan (complete if return to normal duties is estimated to be greater than 10 days)

Treatment: \_\_\_\_\_

Medication prescribed: Panadeine Forte

Referred to specialist (specialty/name): \_\_\_\_\_

Referred to allied health professional (discipline/name): Physiotherapist

Other (specify): Gym program

### PART E

#### Rehabilitation and return to work plan

Approval is provided for a suitable duties program with the following guidelines

	No	Occasional	Frequent	Comments
Lifting: weight limit _____ kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bending/twisting/squatting	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Standing/sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<u>alternate sit/stand/walk - max sit 30 mins</u>
Right/left-handed work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Driving or operating machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pushing/pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Keep wound clean and dry

Other considerations (specify): \_\_\_\_\_

Restricted hours (specify): 4 hrs/day increasing in week 2 as tolerated

Restricted days (specify): \_\_\_\_\_

I require a suitable duties program to be provided to me for approval

Contact has been made with the employer

I wish to be involved in the rehabilitation process

### PART F

#### Medical/Dental Practitioner Details (please print clearly or use practice or hospital stamp)

Doctor's name: Dr Peter Jones Practice/hospital name: Jones Medical

Postal address: PO Box 1111, Brisbane 4000

Ph: 32345678 Fax: 32345688 Email: peter.jones@medimail.com

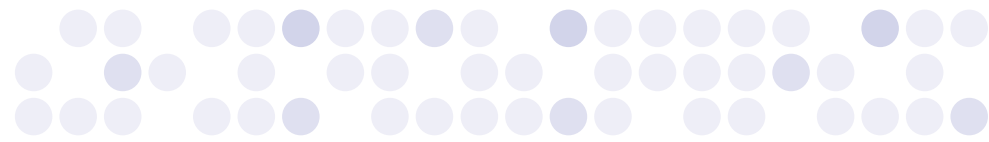
Signature: \_\_\_\_\_ Date: 28 / 01 / 2009

Practice/hospital Stamp Here

For general information about workers' compensation visit [www.qcomp.com.au](http://www.qcomp.com.au)

VERSION 3

Original signed copy – Insurer | Second copy – Employer | Third copy – Worker | Fourth copy – Medical/Dental Practitioner



## Part A

As you can see from the sample, the workers' compensation medical certificate is divided into several sections:

### Part A

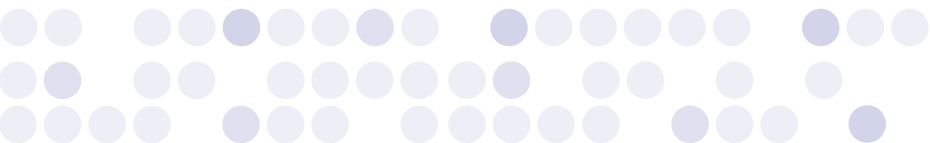
Part A of the certificate relates to the injured worker details and shows:

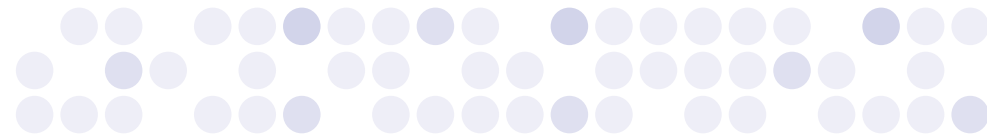
- attendance date, worker's name, worker's contact details and employer name
- a diagnosis rather than symptoms
- the worker's stated date of injury and worker's stated cause of the injury
- pre-existing factors (indicated if the doctor considers that their patient has a condition or illness relevant to the work related injury).

Worker's capacity for work shows whether the doctor believes their patient:

- is fit to return to their normal duties (should specify a date)
- may require some modification to their duties (suitable duties)
- may be unable to return to work at all
- may require more than one of the options shown at any particular time.

Medical management indicates the period that the worker will require ongoing or further treatment. Details of the treatment are shown in Part D.





## Parts B, C and D

### Part B

Part B provides a space for doctors to indicate whether further information is needed or where the doctor would like to discuss the medical aspects with the insurer. If the doctor would like the insurer to contact them they will indicate their request by ticking the box and providing details of their preferred method of contact.

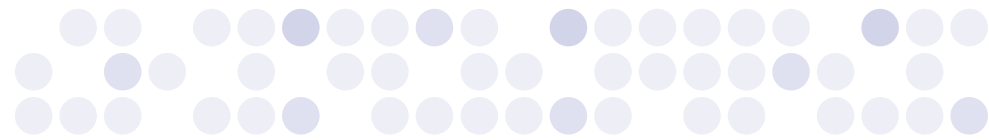
### Part C

Part C is used to indicate the doctor's diagnostic plan. The doctor will complete this section if they are ordering diagnostic tools such as imaging or pathology to assist in further defining the worker's diagnosis.

### Part D

Part D provides a brief outline of the doctor's medical management plan for the worker. The doctor will complete this section when the period of total or partial incapacity is not known, is uncertain or is likely to be more than 10 days.





## Parts E and F

### Part E

Part E details the doctor's guidelines for developing a suitable duties program. The doctor will tick the approval box to indicate to the insurer and the employer their approval for the set up of a suitable duties program that contains the elements indicated on the certificate.

This part of the certificate provides space for the doctor to indicate whether the suitable duties program should include:

- restricted hours (how many hours per day the worker is fit to work)
- restricted days ( how many days per week the worker is fit to work and whether these should be consecutive).

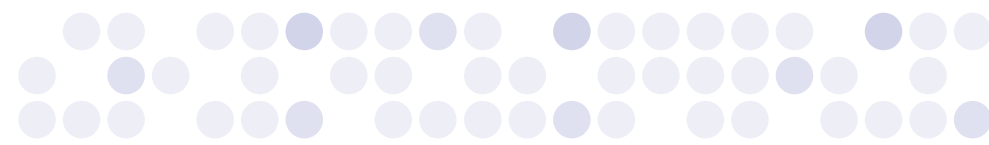
Part E also allows the doctor to indicate:

- whether the suitable duties program should be provided to them for approval (they will tick this box if they would prefer the insurer to organise for a suitable duties program to be set up by a rehabilitation professional and then sent to them for approval)
- whether the doctor has spoken with the worker's employer about the management of the injury
- that they are available for advice and consultation, as required, for the worker's rehabilitation management. If they do not tick this box the insurer will make other arrangements for rehabilitation coordination, but will still require the doctor's approval of suitable duties programs.

**Part F** – This section is mandatory

The workers' compensation certificate must be signed and dated by the worker's treating doctor in every case. Practice contact details must also be visible and legible on all copies of the certificate.





# Sample suitable duties program

This is an example of a suitable duties program based on the information contained in John's medical certificate. For more information on how to develop a suitable duties program visit the *Developing suitable duties programs* section of our website.

Injured worker details		Plan details	
Worker:	John Smith	Phone number:	2345 5678
Supervisor:	Mark Brown	Phone number:	2345 6788
Treating medical practitioner:	Dr Peter Jones	Phone number:	2334 5678
Job description: Assistant to Project Manager		Fit for suitable duties (restricted return to work?) From: 02/02/2009 to: 13/02/2009	
<b>Task details</b>			
Week		Duties	Restrictions
Week one commencing: 02/02/2009		Telephone and email ordering of construction materials Liaising with suppliers / construction supervisors, checking deliveries, completing necessary computer records relating to ordering	No lifting over 5kg No bending / twisting Sitting for 30 min periods alternating with standing/walking
Hours: 4 hours per day (9:30am-1:30pm)	Days: Monday to Friday		
Week two commencing: 09/02/2009		As per week 1	As per week 1
Hours: 6 hours per day (9:30am-3:30pm)	Days: Monday to Friday		
Treatment during this plan : physiotherapy, gym strengthening program		Training required: yes	
		To be given by: Tony White, Project Manager on 02/02/2009	
Plan to be reviewed: 06/02/2009			
<b>Signatures</b>			
Name (treating medical practitioner):	Dr Peter Jones	Name (worker):	John Smith
Approval as per WC medical certificate dated 02/02/2009 – 13/02/2009		I have been consulted about the content of this plan and agree to participate	
		Signature: <i>J. Smith</i>	Date: 30/01/2009
Name (supervisor) T.J. White	30/01/2009	Name (rehabilitation and return to work coordinator)	Maree Celeste
I agree to ensure this plan is implemented in the work area		I agree to monitor this plan	
Signature: <i>T.J. White</i>	Date: 30/01/2009	Signature: <i>M.R. Celeste</i>	Date: 30/01/2009