



FORM 4
Workers' Compensation and Injury Management Act 1981
(Section 61(1))



Workers' Compensation FINAL Medical Certificate

Claim No.
(If known)

1. To (name and address of worker's employer)

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.....

2. Worker's Details

First name(s): Surname:

Address:

..... Telephone: 08

Date and place of occurrence of injury: On..... / /, at

3. Medical Assessment

Having examined the worker, it is my opinion that as from:

..... / /

- the worker has total capacity for work.
- the worker has partial capacity for work.
- the worker's incapacity is no longer a result of the injury.

It is also my opinion that as from:

..... / /

- the worker is fit.
- the worker is fit for alternative duties with the following limitations:

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Grounds for the opinion in medical assessment:

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4. Medical Practitioner's Details

Name: Registration No:

Address:

Telephone: Fax:

Time & Date of examination: Signature: