[r.10(1)]

Workers' Compensation and Injury Management Act 1981

(Section 69)

DECLARATION OF WORKER NOT RESIDING IN W.A.

IF A WORKER RESIDES OUTSIDE THE STATE, PROOF OF THE WORKER'S IDENTITY AND CONTINUING INCAPACITY IS REQUIRED EVERY 3 MONTHS

PART 1 - WORKER'S DECLARATION

WORKER'S DETAILS

First name		Last name	
Date of birth	/ /	Claim no.	
Phone		Email	
Address			
Date of injury			

DETAILS OF EMPLOYER or EMPLOYER'S INSURER

Name of employer and employer's insurer	
Address	
Email	

DECLARATION BY WORKER

I have truthfully answered all the questions I have been asked and have fully cooperated to the best of my ability during the course of the medical examination by the medical practitioner named in PART 2 of this declaration.

Worker print name			
Worker's signature			
Date of declaration	/ /	Date sent to employer or employer's insurer	/ /

Sent by: Email ☐ Post ☐ Fax ☐

PART 2 - MEDICAL PRACTITIONER'S DECLARATION

MEDICAL ASSESSMENT

Date of this assessment / / Date of injury / /

I declare that I have examined the person named in PART 1 of this declaration and I have confirmed that the person who I examined was that person through the sighting of an official document of the government of the country in which the person resides.

The document I used to confirm identification about the person was (for example a passport):

MEDICAL MANAGEMENT

Clinical findings/ diagnosis

Medication:	
Imaging:	
Referral to specialist or hospital (name)	
Approved health treatments (specify type and number of sessions)	

WORK CAPACITY

Worker's usual duties

I find this worker to have:

- ☐ **full capacity for work** from / / ☐ but requires further treatment
- ☐ **some capacity for work**, from / / to / / performing:
  - ☐ pre-injury duties ☐ modified or alternative duties ☐ workplace modifications
  - ☐ pre-injury hours ☐ modified hours of ____ hrs/day ____ days/wk
- ☐ **no capacity for any work** from / / to / /

Specify any work restrictions below. Where there is no capacity for work, please provide clinical reasoning.

MEDICAL PRACTITIONER'S DETAILS

Name

Address

Phone

Email

(Practice stamp – optional)

Medical registration number/ country

Medical specialty

Signature

Date / /