ReturntoWorkSA

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Emergency Department

Nurse Practitioner Work Capacity Certificate

A. Patient and employer details

Family name: _____ Given names: _____

Claim number (if known): _____ Employer name: _____

Date of birth: DD / MM / YYYY

B. Injury details and assessment

I examined you on: DD / MM / YYYY for injury(s)/condition(s) you stated occurred/developed on: DD / MM / YYYY

The stated cause was: _____

_____

The injury(s)/condition(s) you presented with is/are consistent with your stated cause(s) ☐ Yes ☐ No

My clinical diagnosis/es based on my examination of you and other available information is: _____

_____

_____

Other comments/clinical findings: _____

_____

_____

_____

C. Certification (for a maximum period of 7 days)

In my opinion, you: (please tick whichever apply)

☐ have recovered from your injury/condition and are fit to return to your normal duties and hours on: DD / MM / YYYY

☐ some further treatment may be required

☐ are fit to perform suitable duties that accommodate your functional abilities from: DD / MM / YYYY to DD / MM / YYYY

☐ are medically unfit to undertake suitable duties while recovering from your injury for ____ days (up to and including a maximum of 7 days).

Note: Certification based on functional capacity, not available duties.

Reason: _____

Comments: _____

D. Nurse Practitioner's details

Nurse Practitioner's name: _____

Address: _____ Signed: _____

Provider Number: _____ Completion date: DD / MM / YYYY

Please attend a General Practitioner for ongoing treatment and certification.