Work Capabilities Form

WHS-PRO-FORM-006a

JAMES COOK UNIVERSITY AUSTRALIA

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The JCU staff member is to provide this form to their treating medical practitioner. The treating medical practitioner is to complete the form, identifying the staff member's physical capacity or limitations. This information is then used to assist with the creation of a Suitable Duties Plan if necessary. This completed form is to be made available to the staff member's Supervisor/Manager and the JCU WHS Injury Prevention & Management Advisor.

Name: _____ DOB: _____/_____/_____

I have examined the above patient on (date): _____ and certify that he/she has been diagnosed with the following:

_____

_____

Fitness for work

❒ Fit to carry out pre-injury duties commencing on (date) _____/_____/_____

❒ Fit and capable of performing selected duties from (date) _____/_____/_____ to _____/_____/_____

❒ Unfit for any kind of work from (date) _____/_____/_____ to ____/_____/_____

Recommended work hours

❒ Usual work hours ❒ Reduced work hours: _____ hours per day _____ days per week.

Duties may include:	Not restricted	Frequent	Occasional	Minimal	None
Sitting					
Standing					
Walking					
Climbing stairs					
Bending/Twisting/Squatting					
Reaching below waist to ground level					
Reaching to waist/chest height					
Reaching to overhead height					
Grip Activities					
Lifting/carrying using right / left hand up to____ kg					

Duties may include:	Not restricted	Frequent	Occasional	Minimal	None
Lifting/carrying using both hands up to _____ kg					
Pushing / Pulling					
Computer work (including frequent breaks)					
Operating Machinery					
Driving					

Other: Recommendations / Comments

- ❒ Symptom management breaks for _____ minutes every _____ hours
- ❒ Rotation of tasks every _____ mins / hours
- ❒ Introduction of or increase in social interaction
- ❒ Impact of medication _____
- ❒ Psychological considerations _____
- ❒ Other _____

_____

_____

Review Date: _____/_____ /_____

Expected time to return to full pre-injury duties: _____ (weeks) _____(months)

(Please note: generally the business expects employees to return to full pre-injury hours and duties within 3 months of commencement of a return to work plan)

Treating Doctor Signature: _____

Treating Doctor Name: _____

Date: ___/___ /_____

Practice Stamp