

Work Capabilities Form

WHS-PRO-FORM-006a



Electronic copies of this form are current. All other copies are uncontrolled and currency can only be assured at the time of printing

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 | | | | | |

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| 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: ____/____/____

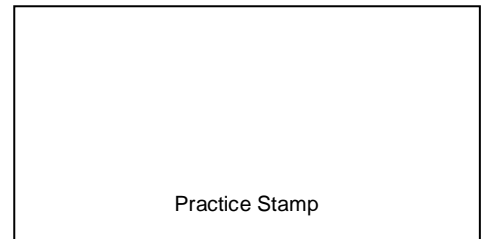
Expected time to return to full pre-injury duties: _____ (weeks) _____ (months)

(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