WC301*

Workers' Compensation and Injury Management Act 1981

Workers' Compensation and Injury Management Amendment Regulations 2014

Made by the Governor in Executive Council.

1. Citation

These regulations are the *Workers' Compensation and Injury Management Amendment Regulations 2014*.

2. Commencement

These regulations come into operation as follows —

(a) regulations 1 and 2 — on the day on which these regulations are published in the *Gazette*;

(b) the rest of the regulations — on 1 July 2014.

3. Regulations amended

These regulations amend the *Workers' Compensation and Injury Management Regulations 1982*.

4. Regulation 6A amended

In regulation 6A(2) delete "is to" and insert:

must

Note: The heading to amended regulation 6A is to read:

Form of first certificate of capacity

5. Regulation 7 amended

In regulation 7(1) delete "medical certificate" (each occurrence) and insert:

certificate of capacity

6. Regulation 7A inserted

After regulation 7 insert:

7A. Form of progress certificate of capacity

Form 4A in Appendix 1 is prescribed as a certificate for the purposes of section 61(1) of the Act.

7. Regulation 8 amended

In regulation 8(1), (2) and (3) delete "First Medical Certificate" and insert:

first certificate of capacity

8. Appendix I amended

(1) In Appendix I Form 2B delete "first medical certificate" and insert:

first certificate of capacity

(2) In Appendix I Form 2B delete "medical certificate/s" and insert:

certificate/s of capacity

(3) Delete Appendix I Form 3 and insert:

Form 3

[r. 6A and 7(1)]

Workers' Compensation and Injury Management Act 1981

(Sections 57A(1)(b), 57B(1)(b) and 61(1))

FIRST CERTIFICATE OF CAPACITY

1. WORKER'S DETAILS

First name | Last name

Date of birth / / | Email

Phone | Mobile

Address

2. EMPLOYMENT DETAILS

Worker's job title | Employer's name

Employer's address

3. CONSENT AUTHORITY

I consent to any medical practitioner who treats me (whether named on this certificate or not) to discuss my medical condition with my employer, insurer and other medical or allied health professionals for the purpose of my claim for workers' compensation and return to work options.

Worker's signature | Print name

Date / /

4. WORKER'S DESCRIPTION OF INJURY

Date of injury / /

What happened?

Worker's symptoms

5. MEDICAL ASSESSMENT

Date of this assessment / /

Clinical findings

Diagnosis

The injury is consistent with worker's description of how injury occurred ☐ yes ☐ no ☐ uncertain

The injury is: ☐ a new condition ☐ a recurrence of a pre-existing condition

6. WORK CAPACITY

Worker's usual duties

Having considered the health benefits of work, 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 / / *(outline clinical reasons below)*

Worker has capacity to:

(Please outline the worker's physical and/or psychosocial capacity — refer to explanatory notes for examples. Where there is no capacity for work, please provide clinical reasoning.)

☐ lift up to ☐ kg

☐ sit up to ☐ mins

☐ stand up to ☐ mins

☐ walk up to ☐ m

☐ work below shoulder height

7. INJURY MANAGEMENT PLAN

Activities/interventions	Purpose/goal *(likely change in symptoms, function, activity and work participation)*

I would like: ☐ more information about available duties

☐ a RTW program to be established

☐ to be involved in developing the RTW program

Examples of injury management activities/interventions include:

- *further assessment — diagnostic imaging, medical specialist consults, worksite assessment;*
- *intervention — physiotherapy, clinical psychology, exercise physiology, prescribed medications, workplace mediation;*
- *return to work planning — identify suitable duties, establish return to work program.*

8. NEXT REVIEW DATE

☐ Worker does not need to be reviewed again (FIRST and FINAL certificate of capacity)

☐ I will review worker again on / / *(If greater than 14 days, please provide clinical reasoning)*

Comments

9. MEDICAL PRACTITIONER'S DETAILS

Name AHPRA no. MED

Address Email

Signature

Phone

Fax Date / /

(Practice stamp — optional)

(4) Delete Appendix I Form 4 and insert:

Form 4

[r. 7(1)]

Workers' Compensation and Injury Management Act 1981

(Section 61(1))

FINAL CERTIFICATE OF CAPACITY

1. WORKER'S DETAILS

First name Last name

Date of birth / / Claim no.

Phone Email

Address

2. EMPLOYER'S DETAILS

Employer's name | Employer's phone

Employer's address

3. MEDICAL ASSESSMENT

Date of this assessment / / Date of injury / /

☐ The worker's condition is unlikely to change substantially in the next 12 months.

4. WORK CAPACITY

Having considered the health benefits of work, I find this worker to have:

☐ full capacity for work from / / ☐ but requires further treatment *(specifics below)*

☐ capacity for work performing ☐ hours per day and ☐ days per week from / /

as outlined below:

(Please outline the worker's physical and/or psychosocial capacity for work, functional limits, ongoing need for workplace modifications, and/or further treatment needs)

☐ lift up to ☐ kg

☐ sit up to ☐ mins

☐ stand up to ☐ mins

☐ walk up to ☐ m

☐ work below shoulder height

☐ The worker's incapacity is no longer a result of the injury.

5. REASON FOR CAPACITY/INCAPACITY

Please outline your clinical reason for the worker's capacity/incapacity:

6. MEDICAL PRACTITIONER'S DETAILS

Name | AHPRA no. MED

Address | Email

Signature

Phone

Fax | Date / /

(Practice stamp — optional)

Form 4A

[r. 7A]

Workers' Compensation and Injury Management Act 1981

(Section 61(1))

PROGRESS CERTIFICATE OF CAPACITY

1. WORKER'S DETAILS

First name | Last name

Date of birth / / | Claim no.

Phone | Email

Address

2. EMPLOYER'S DETAILS

Employer's name | Employer's phone

Employer's address

3. MEDICAL ASSESSMENT

Date of this assessment / / | Date of injury / /

Diagnosis

4. PROGRESS REPORT

Activities/interventions	Actual outcome *(change in symptoms, function, activity and work participation)*	Still required?*
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

** (If management activities/interventions are still required, please also list them in Section 6 "Injury management plan".)*

☐ Other factors appear to be impacting recovery and return to work.

Comment

5. WORK CAPACITY

Worker's usual duties

Having considered the health benefits of work, 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 / / *(outline clinical reasons below)*

Worker has capacity to:

(Please outline the worker's physical and/or psychosocial capacity — refer to explanatory notes for examples. Where there is no capacity for work, please provide clinical reasoning.)

☐ lift up to	☐ kg	
☐ sit up to	☐ mins	
☐ stand up to	☐ mins	
☐ walk up to	☐ m	
☐ work below shoulder height		

6. INJURY MANAGEMENT PLAN

Activities/interventions	Purpose/goal *(likely change in symptoms, function, activity and work participation)*

☐ I support the RTW program established by the employer/insurer/WRP dated / /

☐ I would like more information about available duties

☐ I would like to be involved in developing the RTW program

☐ Please engage a workplace rehabilitation provider *(If you have made a referral, provide name and contact details below)*

Examples of injury management activities/interventions include:

- *further assessment — diagnostic imaging, medical specialist consults, worksite assessment;*
- *intervention — physiotherapy, clinical psychology, exercise physiology, prescribed medications, workplace mediation;*
- *return to work planning — identify suitable duties, establish return to work program.*

7. NEXT REVIEW DATE

☐ I will review worker again on / / *(If greater than 28 days, please provide clinical reasoning)*

Comments

8. MEDICAL PRACTITIONER'S DETAILS

Name | AHPRA no. MED

Address | Email

Signature

Phone

Fax | Date / /

(Practice stamp — optional)

(5) In Appendix I Form 5 delete "medical certificates" and insert:

certificates of capacity

R. KENNEDY, Clerk of the Executive Council.