ACT Government | Motor Accident Injuries Commission

FITNESS FOR WORK CERTIFICATE

To be completed by a treating doctor for the injured person.

1. Patient details

Patient's first name | **Middle name(s)** | **Last name**

Date of birth (dd/mm/yyyy) | **Occupation** | **Date of the motor accident**

Diagnosis of motor accident related injury or injuries

2. Fitness for work

Is the patient fit for work?

☐ Yes, fit for work in previous role with no restrictions ▶ **Skip to section 3**

☐ Yes, with reduced capacity ▶ **From** **until** **Date of next review**

Hours, duties and types of work that can be performed

☐ No, patient unfit for work ▶ **From** **until** **Date of next review**

Please indicate an anticipated timeframe for recovery, and factors impacting the person's ability to recover

Note: A certificate is to cover a prospective period of up to one month. *Please attach a statement if you consider that a certificate should cover a longer period to satisfy the insurer the longer period is acceptable. A certificate can not be back-dated more than 13 weeks. A review date is to be on or before the expiry of this certificate.*

3. Treatment

Is treatment likely to be required during the period covered by this certificate?

☐ No treatment necessary

☐ Yes ▶ **Proposed treatment type and duration, including details of referrals to another health practitioner**

4. Doctor's information

Doctor's name

Work phone number

Specialty

Provider Number

Name of practice / hospital

If stamp available, place here

Practice address / hospital address

☐ *I confirm I am a treating doctor / member of a treating practice, nominated for the ongoing management of the patient's treatment and recovery from their motor accident injuries.*

5. Doctor's declaration

I declare that I am a registered medical practitioner and to the best of my knowledge, the information given in this form is true and correct.

Doctor's Signature

Date (dd/mm/yyyy) / /

6. Work declaration *(to be completed by the injured person)*

Patient's first name

Middle name(s)

Last name

MAI Application Identifier

Have you engaged in any form of paid work since the last certificate was provided that you have not yet declared to the insurer?

☐ No

☐ Yes ▶ **If yes, please provide details**

Signature of injured person

Date (dd/mm/yyyy) / /