Certificate of capacity/ certificate of fitness

NSW GOVERNMENT | State Insurance Regulatory Authority

For use with workers compensation and Compulsory Third Party (CTP) motor accident injury claims.

☐ CTP ☐ Workers compensation

For CTP claims: 'Certificate of fitness' means 'certificate of fitness for work'. This certificate should be completed whether the person was employed at the time of the accident or not.

☐ Tick if this is the initial certificate for this claim.

Section 1: To be completed by the injured person or treating medical practitioner

First name: JANE

Last name: DOE

Date of birth (DD/MM/YYYY): 01/01/1989

Telephone number: 0423 456 789

Address (must be residential address – not PO Box): Kirribilli House, Kirribilli Ave

Suburb: Sydney

State: NSW

Postcode: 2000

Claim number: NA

Medicare number: 598645687/1

Occupation/job title: Cabin Crew

Employer's name and contact details (if applicable): QANTAS

Injured person's consent

I consent to my treating medical practitioner, my employer (optional for CTP claims), the insurer, other medical practitioners or health related practitioners (whether consulting, treating or examining), workplace rehabilitation providers and SIRA exchanging information for the purpose of managing my injury and workers compensation/motor accident injury claim.

I understand this information will be used by SIRA and insurers to fulfill their functions under the motor accident insurance and workers compensation legislation.

Signature:

Date (DD/MM/YYYY): 01/04/2026

Section 2: To be completed by treating medical practitioner

Medical certification

Diagnosis of work related injury/disease or motor accident related injury(ies): Provisional Rotator Cuff Injury (Right Shoulder)

Person's stated date of injury/accident (DD/MM/YYYY): 01/04/2026

Shaded areas to be completed for initial certificate only

Person was first seen at this practice/hospital for this injury on (DD/MM/YYYY): 01/04/2026

Injury is consistent with person's description of cause: ☑ Yes ☐ No ☐ Uncertain

How is the injury related to work or the motor vehicle accident?

Sustained acute strain to the right shoulder while attempting to close a heavy door at the workplace.

Detail any pre-existing factors which may be relevant to this condition or injury(ies)

None

First name | Last name | Claim number

Management plan for this period

Treatment/medication type and duration

Referral for physiotherapy and diagnostic ultrasound.
anti-inflammatory prescription provided

Referral to another health service or rehabilitation provider (include details of provider type and service requested, duration and frequency when relevant)

Physiotherapy 1-2 times per week and graduated increase in range of motion as tolerated

Capacity for activities – If the person has capacity for pre-injury work this section does not need to be completed. For all others please consider activities of daily living currently being performed.

Lifting/carrying capacity: No lifting/carrying with the right arm.

Sitting tolerance: Pre-injury capacity

Standing tolerance: pre-injury capacity

Pushing/pulling ability: No pushing or pulling with the right arm.

Bending/twisting/squatting ability: pre-injury capacity

Driving ability: should not drive

Other (please specify) eg psychological considerations, keep wound clean and dry

Typing and keyboard use are permitted with the right hand; no restrictions apply to the left hand

Next review date (DD/MM/YYYY) (if greater than 28 days, please provide clinical reasoning)

Comments

The worker has full functional use of the left arm and restricted use of the right arm.
The right hand is able to push, pull, lift or carry light objects like a pen, phone or cup

Ground duties only please

Capacity for work (please consider the health benefits of good work when completing this section).

Where the word 'capacity' appears below it should be read as 'fitness for work' when the certificate is completed in a motor accident injury claim.

Do you require a copy of the position description/work duties? ☐ Yes ☐ No

	Date (DD/MM/YYYY)
☐ is fit for pre-injury work from	

☑ has capacity for some type of work from	01/04/2026	to	6/04/2026	for	8	hours/day	5 days/week
☐ has no current capacity for any work from		to					

If no current capacity for work, estimated time to return to any type of employment

Factors affecting recovery

Expected to improve with conservative management.

First name | Last name | Claim number

Treating medical practitioner details

I certify that I am the treating medical practitioner and I have examined this person. The information and medical opinions contained in this certificate are, to the best of my knowledge, true and correct.

Signature

Date (DD/MM/YYYY) 01/04/2026

Dr Jon Field

Address

DOCTO

Suburb: Broadbeach | State: QLD | Postcode: 4218

Telephone number: 07 3497 3383 | Provider number:

☐ I agree to be the nominated treating doctor for the ongoing management of this person's injury, treatment and recovery at/return to work (tick if you consent).

Section 3: Employment declaration (not to be completed by the treating medical practitioner)

This section is to be completed by the person prior to sending to the insurer (or employer).

First name | Last name

☐ I have ☐ I have not (tick appropriate box)

engaged in any form of paid employment, self employment or voluntary work for which I have received or am entitled to receive payment in money or otherwise since the last certificate was provided, that I have not yet declared to the insurer.

If so, please provide details below.

I declare that the details I have given on this declaration are true and correct, knowing that false declarations are punishable by law.

Signature | Date (DD/MM/YYYY)

Catalogue No. SIRA08719
State Insurance Regulatory Authority, 92-100 Donnison Street, Gosford, NSW 2250
Locked Bag 2906, Lisarow, NSW 2252 | Customer Experience 13 10 50
Website www.sira.nsw.gov.au

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