

Centrelink customers: did you know? You can lodge this certificate with us using Online Services or one of our Express Plus Apps.
Go to servicessaustralia.gov.au/submitdocumentsonline

Patient's details

Family name

First name

Second name

Date of birth / /

CRN - - -

Home address

Postcode

This person has been: My patient since / /

A patient of this practice since / /

Primary condition

Diagnosis — List the main medical conditions which impact on the patient's capacity to work or study
(Primary condition should be the condition with the **most** impact).

Secondary/Related condition(s)

Date of onset (if known) / /

Is this condition – Tick **one** only

Temporary Permanent Temporary exacerbation
(likely to persist for 2 years or more) (likely to persist for 2 years or more) of a permanent condition

Date of onset (if known) / /

Is this condition – Tick **one** only

Temporary Permanent Temporary exacerbation
(likely to persist for 2 years or more) (likely to persist for 2 years or more) of a permanent condition

Prognosis

— Estimate how long the symptom(s) will affect the patient's capacity to work or study.

Less than 3 months 3–12 months 13–24 months More than 24 months Uncertain

Less than 3 months 3–12 months 13–24 months More than 24 months Uncertain

Symptoms

— List current symptoms for each condition.

Treatment

— Describe the patient's treatment regime, including past, current and planned treatment.

Past:

Current:

Planned:

Past:

Current:

Planned:

Give details of any other medical conditions which impact on the patient's capacity to work or study.

Capacity to work or study

In my opinion the patient is/has been unfit for work/study
from / / to / /

Can the patient do any other work for 8 hours or more per week?
Yes No

In order to prepare your patient for return to work or study, certain assistance may be offered. Identify any factors which may impact on participation.

Certification by Medical Practitioner

Doctor's name (printed)

Qualifications Provider no.

Surgery/Medical Centre/Hospital name

Address

Postcode

Phone number

Signature

Date / /



CLK0SU415 2009