WorkReady Report – Certificate of Physical Capacity

Employee Name: APS Number:

Work Centre: DOB: / / Date of Injury: / /

Diagnosis:

The patient described the condition as caused by:

Duties: I confirm that I have reviewed the duties information in the **Suitable Duties Guide** ☐ Yes ☐ No

Activity recommendations:
Please tick applicable (i.e. 1 box each line)
If no box is ticked, this will be taken as NO restriction for this action or not applicable.

Related to presenting injury, the worker can:	Not restricted	Perform occasionally (<33%)	Perform seldom (<10%)	Unable to perform
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐
Walk	☐	☐	☐	☐
Climb (ladder / stairs)	☐	☐	☐	☐
Twist	☐	☐	☐	☐
Bend / stoop	☐	☐	☐	☐
Squat / kneel	☐	☐	☐	☐
Work above shoulders (L, R, B)	☐	☐	☐	☐
Keyboard (L, R, B)	☐	☐	☐	☐
Grasp (forceful) (L, R, B)	☐	☐	☐	☐
Fine manipulation (L, R, B)	☐	☐	☐	☐
Push / Pull	☐	☐	☐	☐
Lift / Carry	☐	☐	☐	☐
Drive motor vehicle / van	☐	☐ ____kg	☐ ____kg	☐
Ride motorcycle (if applicable)	☐	☐	☐	☐
Drive Truck (if applicable)	☐	☐	☐	☐
Ride bicycle (if applicable)	☐	☐	☐	☐
Operate a forklift (if applicable)	☐	☐	☐	☐

Please note: Australia Post should be able to provide duties if any of the above are ticked as suitable.

Additional comments:

Fitness for work:
(including overtime)

Treatment, investigation and referrals:

Duration of this report from: / / **to:** / / (inclusive) ☐ Tick if final certificate

OR: Having assessed the employee against the above activities I certify him/her unfit for all duties above from: / / to: / /

In your opinion, the worker's employment is a contributing factor to this injury: ☐ Yes ☐ No ☐ Unsure

Pre-existing or other possible contributing factors?

Doctors name: (Please print) **Stamp:** **Telephone:**

Signature: **Date of consultation:** / /

PLEASE FAX THIS REPORT TO THE EMPLOYEE'S MANAGER AND PROVIDE SIGNED ORIGINAL TO EMPLOYEE