Work Capacity Document

To be completed by the employee's treating Medical Practitioner to

Employee Details
Name:
Job title:
Injury/Illness:
D.O.I.:

Treating Medical Practitioners Details
Name:
Practice:
Signature:

Following an examination of the worker and a review of the pl
opinion that he/she is currently:

☐ Fit for normal duties

☐ Totally unfit for any work duties

☐ Fit for alternative duties as per the work restrictions outlined

Work Restrictions	Normal	Rest
Work hours	☐	☐
Shift Type	☐	☐
Lifting and carrying	☐	☐
Bending and Twisting	☐	☐
Stair Climbing	☐	☐
Ladder Climbing	☐	☐
Sitting (consider duration)	☐	☐
Standing (consider duration)	☐	☐
Walking (duration / uneven ground)	☐	☐
Squatting / Crouching	☐	☐
Kneeling	☐	☐
Above shoulder height work	☐	☐
Working at reach	☐	☐

Specific task restrictions *(vibration, tool use, grip, push/pull*

Travel restrictions	
Is the employee fit to travel on an aircraft?	☐ Y
Is the employee fit to drive a manual industrial vehicle?	☐ Y
Is the employee fit to work in remote locations? *(consider thermal stress / limited access to facilities)*	☐ Y

Personal Protective Equipment

Is the employee restricted from using PPE? (Please tick those which