

Workers' Compensation and Injury Management Act 1981
(Section 69)

DECLARATION OF WORKER NOT RESIDING IN W.A.

IF A WORKER RESIDES OUTSIDE THE STATE, PROOF OF THE
WORKER'S IDENTITY AND CONTINUING INCAPACITY IS
REQUIRED EVERY 3 MONTHS

PART 1 - WORKER'S DECLARATION

WORKER'S DETAILS

First name	<input type="text"/>	Last name	<input type="text"/>
Date of birth	<input type="text" value="/"/> <input type="text" value="/"/>	Claim no.	<input type="text"/>
Phone	<input type="text"/>	Email	<input type="text"/>
Address	<input type="text"/>		
Date of injury	<input type="text"/>		

DETAILS OF EMPLOYER or EMPLOYER'S INSURER

Name of employer and employer's insurer	<input type="text"/>
Address	<input type="text"/>
Email	<input type="text"/>

DECLARATION BY WORKER

I have truthfully answered all the questions I have been asked and have fully cooperated to the best of my ability during the course of the medical examination by the medical practitioner named in PART 2 of this declaration.

Worker print name	<input type="text"/>		
Worker's signature	<input type="text"/>		
Date of declaration	<input type="text" value="/"/> <input type="text" value="/"/>	Date sent to employer or employer's insurer	<input type="text" value="/"/> <input type="text" value="/"/>

Sent by: Email Post Fax

PART 2 - MEDICAL PRACTITIONER'S DECLARATION

MEDICAL ASSESSMENT

Date of this assessment / /

Date of injury / /

I declare that I have examined the person named in PART 1 of this declaration and I have confirmed that the person who I examined was that person through the sighting of an official document of the government of the country in which the person resides.

The document I used to confirm identification about the person was (for example a passport):

MEDICAL MANAGEMENT

Clinical findings/
diagnosis

Medication:	<input type="text"/>
Imaging:	<input type="text"/>
Referral to specialist or hospital (name)	<input type="text"/>
Approved health treatments (specify type and number of sessions)	<input type="text"/>

WORK CAPACITY

Worker's usual duties

I find this worker to have:

full capacity for work from / / but requires further treatment

some capacity for work, from / / to / / performing:

pre-injury duties modified or alternative duties workplace modifications

pre-injury hours modified hours of hrs/day days/wk

no capacity for any work from / / to / /

Specify any work restrictions below. Where there is no capacity for work, please provide clinical reasoning.

MEDICAL PRACTITIONER'S DETAILS

Name

Medical registration number/ country

Address

Medical specialty

Phone

Signature

Email

Date / /

(Practice stamp – optional)