

*Workers Compensation and Injury Management Act 2023*  
**NON-RESIDENT WORKER — INCAPACITY DECLARATION**

**To**

Insurer:

.....

**Part 1**

**Worker**

Name:

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Address:

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Date of birth:

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Phone number:

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Email address:

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**Employer**

Name:

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Address:

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**Claim**

Insurer claim number:

.....

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**Declaration**

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.

**Signed:**

.....  
(Signed by worker)

**Date:**

.....

## PART 2

### Medical practitioner declaration

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 following document(s) was used to confirm identification of the person:

.....  
Date of assessment: .....

### Medical Management

Clinical findings/ diagnosis: .....

Medication: .....

Imaging: .....

Referral to specialist/ hospital: .....

Approved health treatment: .....

### Work Capacity

Worker's usual duties .....

I find this worker to have:

- Full capacity** for work, from: .....  Requires further treatment
- Some capacity** for work, from: ..... to: .....
- Pre-injury duties     Modified or alternative duties     Workplace modifications
- Pre-injury hours     Modified hours of ..... hrs/day, ..... days/week
- No capacity** for work, from: ..... to: .....

### Work restrictions

(Where no capacity for work, provide clinical reasoning)

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**Medical practitioner**

Name:

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Address:

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Registration number:

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Medical speciality:

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Phone number:

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Email address:

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**Signed:**

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**Date:**

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