Form 86.N

Nurse practitioner workers' compensation certificate

Version 2

Workers' Compensation and Rehabilitation Act 2003

This certificate is an approved form under the *Workers' Compensation and Rehabilitation Act 2003*

☐ New claim ☐ On-going claim Claim number: _____

Injured worker details

I certify that on DD / MM / YYYY I attended (given names) _____

(surname) _____ Date of birth DD / MM / YYYY

Worker's daytime contact phone number: _____

Worker's employer name: _____

He/she was/is suffering from (list all medical diagnoses relevant to the claim):

Diagnosis: _____

_____

Is this is a provisional diagnosis? ☐ Yes ☐ No

If **Yes,** I have ordered: ☐ Diagnostic imaging ☐ Pathology ☐ Other investigation

Details: _____

Worker was first seen at this practice/hospital for this injury/disease on: DD / MM / YYYY

Worker stated date of injury: DD / MM / YYYY

Worker's stated cause of injury: _____

_____

Injury/disease is consistent with worker's description of cause: ☐ Yes ☐ Uncertain

Pre-existing factors or conditions relevant to the diagnosis *(if not previously supplied)*:

_____

Worker's capacity for work (not only pre-injury duties)

Please consider the "health benefits of work" when certifying the worker's capacity.

☐ Fit to return to normal duties from: DD / MM / YYYY

☐ Not able to work at all from: DD / MM / YYYY to DD / MM / YYYY *(up to 10 days from date of injury)*

☐ Worker will be reviewed again on: DD / MM / YYYY

☐ Worker to be reviewed by a medical practitioner before returning to work

Referred to: _____

Further information (optional)

Details of findings/clinical notes relevant to the condition: _____

Medication prescribed: _____

☐ I would like the workers' compensation insurer to contact me upon receipt of this certificate

Preferred method of contact by insurer: ☐ Phone ☐ Fax ☐ Email

Day(s)/time(s): _____

Nurse Practitioner details (please print clearly or use practice or hospital stamp)

Name: _____

Practice/hospital name: _____

Postal address:

Unit/Building No. _____ Street No. _____ Street Name/PO Box _____

Suburb/Town/Locality _____ State _____ Postcode _____

Phone: _____ Fax: _____

Email: _____

Signature: _____ Date: DD / MM / YYYY

For nurse practitioner information about workers' compensation visit qcomp.com.au/i-am-a/medical-professional

Practice/hospital stamp here

Original signed copy – Insurer | Second copy – Employer | Third copy – Worker | Fourth copy – Nurse Practitioner

www.qcomp.com.au

Claim enquiries:

WorkCover Queensland 1300 362 128

Self Insurance or other enquiries 1300 361 235

Under the *Workers' Compensation and Rehabilitation Act 2003* and earlier Queensland workers' compensation legislation, the workers' compensation insurer is authorised to collect the information on this form to process the claimant's application for compensation. Some or all of the information contained in this form may be disclosed to the claimant's employer, another insurer, medical or allied health providers or any other workers' compensation authority in any jurisdiction.

This form was approved by the Workers' Compensation Regulator, on 11 April 2014, pursuant to section 586 of the *Workers' Compensation and Rehabilitation Act 2003*.

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