

Work Capabilities Notification Form

Charles Darwin University is committed to ensuring its employees are fit to undertake their duties and has a return to work program that may provide suitable duties / hours to an employee who has suffered a non-work-related injury/illness.

Duties can be tailored from sedentary office work only, up to full field duties (where applicable) – these can be introduced gradually as the injury improves, to ensure a safe and early return to work. The information provided below by the treating Doctor will assist the University to provide a suitable duties plan, where possible.

Please indicate on the table below any restrictions applicable to the employee. Please indicate how long these restrictions must remain in place, and / or when the next medical review is required.

Surname		First Names		D.O.B.	
Job Title			Supervisor		
Injury	Non-Work-Related	Description			

Please indicate - Fit for all pre-injury duties / Fit for suitable duties (*complete table below*) / Temporarily unfit (*please provide a medical certificate*)

Restrictions	Okay to perform	Must not perform	Limited to wt, time, etc	Comments
Manual Handling <i>Lifting / Carrying</i>				
Manual Handling <i>Pulling/Pushing</i>				
Climbing stairs / ladders / scaffolding				
Sitting (<i>time each event</i>)				
Standing / Teaching (<i>time each event</i>)				
Stand/Walk (<i>workshop / kitchen / beauty supervision</i>)				
Walking <i>distance limits- even / uneven ground</i>				
Walking <i>distance limits/ uneven ground</i>				
Kneeling - <i>kneel crouch squat crawl</i>				
Activities requiring Balance				
Bend, Stoop, Twist				
Power Tools / Hand Tools				
Hand Use <i>grip, rotation, etc</i>				
Reaching forward / side / over head				
Plant / Vehicle Operation				
Heights / Confined Space / Remote / Work Alone / Heat / Cold				
Repetitive limb use				
PPE				
Field Supervision/Inspection / Office Duties				
Lecturing / Tutoring – <i>face to face – time limits</i>				
Lecturing / Tutoring – <i>online – time limits</i>				

Normal Hours (*7.35hrs / day; 5 days/wk.*) / **Restricted Hours Required** (*please circle*)

Wk 1 _____ days per Week	_____ hours per day
Wk 2 _____ days per Week	_____ hours per day
Wk 3 _____ days per Week	_____ hours per day
Wk 4 _____ days per Week	_____ hours per day

Comments

Review Required <input type="checkbox"/> Yes / <input type="checkbox"/> No	Referral Specialist _____ / Physiotherapy / Other _____
Date (if yes) _____	

Doctor / Service Provider Name / Stamp	Sign:
	Date: