Medical Certificate

For ACT Corrections Management Regulation—Claim for Compensation - to be completed by a Doctor

AF2014-100
Corrections Management Act 2007 – Form 2

This certificate must be submitted with the Corrections Management Act 2007- Form 1 if you want to make a claim for compensation under the compensation and injury management scheme for detainees.

If you are not completing the form electronically you may attach your response on a separate piece of paper if there is not enough space.

PERSONAL INFORMATION OF INJURED PERSON

LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH: _____

MEDICAL INFORMATION

Date of injury: _____

Date of initial Assessment: _____

Please complete the following four categories, with reference to clinical examination, any investigations, and approved medical guidelines or clinically relevant research.

Description of injury aetiology: _____

Is the injury/aetiology consistent with what the patient has described?

- ◯ Yes
- ◯ No

Diagnosis: _____

Prognosis: _____

Treatment: _____

Note: If this is not the first certificate it is not necessary to complete the above four categories, unless any change has taken place. If there is any change in the four categories in relation to the patient, please state the changes with reference to approved medical guidelines, clinically relevant research and examination or investigations.

Approved form AF 2014-100 approved by Shane Rattenbury MLA, Minister for Corrective Services on 27 September 2014 under section 228 (Approved forms) of the *Corrections Management Act 2007*.

Does the aetiology or diagnosis suggest a pre-existing condition or aggravation of pre-existing condition?

- ◯ Yes
- ◯ No

If yes, please provide details of the pre-existing condition or aggravation.

The question below only needs to be answered where a disease is the cause of a claim for compensation for an injury.

Do you consider the persons injury is consistent with their detention or community service being or having been a substantial contributing factor to the injury?

- ☐ Yes
- ☐ No

TREATMENT PLAN

Treatment that was provided:

- ◯ Nil
- ◯ Short term (<6 weeks)
- ◯ Medium term (6-12 weeks)
- ◯ Long term (>12 weeks)

Referred to specialist

Type:

Name/ Phone number:

Referred to therapy

Type

Name/ Phone number:

Referred to other

Type:

Name/Phone number:

Will the patient be incapacitated for work for a continuous period of longer than 7 days?

- ◯ Yes
- ◯ No

Please indicate the patients fitness for work:

Fit to resume work on:

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Unfit for work from:

Fit for modified or other duties on:

Date of next medical assessment:

MEDICAL PRACTICIONER'S INFORMATION

Name:

Professional qualification:

Provider number:

Practice/ hospital:

Address:

Phone number:

I declare that: I am registered medical practitioner; to the best of my knowledge the information provided here is true and correct; and I am prepared to be my patient's treating doctor for the purposes of the Corrections Management Regulation 2010.

Signature:

Date:

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