



DETAILS OF INJURED EMPLOYEE

DETAILS OF INJURY

[illegible]

If yes, are there any additional contributory causes?



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Has the clinical condition stabilised and not likely to improve? Yes						No			
ICD10 codes									
Impairment findings:									
Date on which the employee is due to return to work:									
DECLARATION									
I declare that after my examination of the above patient, I am satisfied that the injury is work-related and consistent with the injury sustained.									
Surname:					Initials:				
Email:					Tel:				
Practice No:					Cell No:				
Address:									
					Code:				
Signature:					Date:				
IMPORTANT: Please submit all medical reports, radiographs, specialist tests or diagnostic procedures. These are essential if an employee is referred to an assessment clinic.									



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FINAL MEDICAL EVALUATION REPORT

Describe in detail the impairment that has resulted from the injury. This will enable RMA's assessor or the Compensation Commissioner to make a fair assessment of the disablement. Please use the hand, foot, eye or other support forms as required. Where necessary, please submit photographs.

Detailed clinical description:

Name of doctor:

Email:

Tel:

Cell No:

Signature:

Date of evaluation: