



FEDERAL COURT OF AUSTRALIA
PEOPLE & CULTURE

Email: [REDACTED]
www.fedcourt.gov.au

This form is designed to obtain clear, functional information about an employee's capacity for work, including any limitations that may affect their ability to work safely and effectively. The information provided will assist the organisation in determining appropriate, sustainable support measures and identify any reasonable workplace adjustments that may be required to maintain the employee's wellbeing and effective participation in the workplace.

Personal information collected through this form will be handled in accordance with the Privacy Act 1988 (Cth), including the Australian Privacy Principles, and the Agency's Privacy Policy. Please see our [Privacy Policy](#) to see details about how personal information is collected, used, disclosed and managed.

Capacity for Work Information Request – Treating Practitioner Form

Part A – Employee Details

Employee name: _____

Position title: _____ Work location: _____

Part B – Treating Practitioner Details

Practitioner name: _____ Practice name: _____

Provider number (if applicable): _____ Contact phone/email: _____

Part C – Capacity for Work (to be completed by treating practitioner)

Based on your clinical assessment, please indicate the employee's current functional capacity.

- ☐ Fit for normal duties
- ☐ Fit for modified duties (please complete Part D)
- ☐ Not fit for work at this time

If *not fit for work*, is any work capacity expected in the foreseeable future?

- ☐ Yes
- ☐ No
- ☐ Unable to determine at this stage

Part D – Functional Restrictions (if applicable)

Please outline any **functional limitations or restrictions** relevant to work activities. Do not include medical diagnoses or treatment information.

Comments on physical capacity
Comments on mental capacity
Comments on other issues impacting recovery or return to work

Tick or describe as relevant:

☐ Sitting tolerance (duration):

☐ Standing tolerance (duration):

☐ Fatigue considerations:

☐ Walking tolerance:

☐ Lifting/carrying limits:

☐ Postural restrictions (e.g. bending, twisting):

☐ Cognitive demands (e.g. concentration, deci

☐ Fatigue considerations:

☐ Other relevant functional restrictions:

Part E – Hours and Capacity

Please indicate the employee's capacity in relations to hours of work.

Maximum hours per day: _____ Maximum days per week: _____

Any required flexibility or restrictions (e.g. start times, breaks):

Part F – Duration and Review

Date from which this capacity applies: _____

Recommended review timeframe:

☐ 2 – 4 weeks

☐ 4 – 6 weeks

☐ Other (please specify): _____

Part G – Additional Comments (Optional)

Please include any additional capacity-related information that may assist the Agency in understanding safe work participation. Do not include diagnosis, treatment details, or test results.

☐ To assist recovery and return to work, I request a return-to-work case conference with the employer and the employee.

☐ I have discussed the information contained in this form with the named patient.

Part H – Practitioner Declaration

I confirm that the information provided above reflects my professional opinion regarding the employee's functional capacity for work at this time.

Please affix practice stamp here or provide contact details and provider number.

Treating practitioner's signature:

_____ Date _____