ReturntoWorkSA

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Work Capacity Certificate

Version 2 effective 1 July 2017

A. Patient and employer details — Mandatory

Family Name: **Madduri**
Given Names: **Krishna**
Claim Number (if known):
Employer Name: **Australia Post**
Date of Birth: **11/10/1982**

B. Injury details and assessment — Mandatory

I examined you on **26/09/2025** For injury(s)/condition(s) you stated occurred /developed on **05/04/2024**
The stated cause was:
Hit by a car while delivering mail in a bike

The injury(s)/condition(s) you presented with is/are consistent with your stated cause(s): **Yes**
Is this a new injury/condition?: **Yes**
My clinical diagnosis/es based on my examination of you and other available information is:
Thoracic disc bulge and lumbar disc bulge

Other comments/clinical findings:

C. Certification — Mandatory

- [x] Have recovered from your injury/condition and are fit to return to your normal duties: **26/09/2025**
- [ ] Are fit to perform suitable duties that accommodate your functional abilities:
- [ ] Are medically unfit to undertake suitable duties while recovering from your injury for the period:

Reason:

Note: Certification based on your functional ability, not available duties.

- [ ] I estimate you should have functional capacity to return to work days weeks **OR** ☐ uncertain at this stage (estimated timeframe will assist with planning for return to safe work)

I would like to review your progress on **28/11/2025** or at your next medical consultation ☐
Comments:
normal duties at own pace

D. Treatment plan — Complete all fields relevant to your patient

The following treatment plan is aimed at assisting your recovery and return to work:

- [ ] Medical specialist (Name & specialty)
- [ ] Psychologist (Name)

☐ Physiotherapist (Name)
☑ Other (Name & discipline) **massage 6 sessions**

E. Functional ability

Complete all fields relevant to your patient

Your ability to work is affected by **this** injury(s)/condition(s) as follows:
(please select an appropriate response for each function, and indicate any impact medications have on function)

☐ No restrictions - go to section G (Doctor's details)

Physical Function	Can	With modifications	Cannot
Sitting:	☑		
Standing/walking:	☑		
Kneeling/squatting:	☑		
Carrying/holding/lifting:	☑		
Reaching above shoulder:	☑		
Bending:	☑		
Use of affected body part ability:	☑		
Neck movement:	☑		
Climbing steps/stairs/ladders:	☑		
Driving:	☑		

Comments (e.g. details of capacity or limitations that will assist in identification of suitable duties)
no repeated twisting or bending

Mental health function	Not affected	Partially affected	Affected
Attention/concentration:	☑		
Memory (short term and/or long term):	☑		
Judgement (ability to make decisions):	☑		

☐ **Other functional considerations** - not listed above
☐ I have prescribed medication(s) that could impact upon your ability to undertake some activities

Details

I recommend:

- ☐ A graduated increase in working hours over weeks from hours a day to your normal hours/
- ☐ Non-consecutive working days for a period of days or weeks

F. Communication

Optional

Preferred contact method: ☑ Phone ☐ Email ☐ Fax ☐ Writing ☑ Visit

G. Doctor's details

Mandatory

Doctor's Name:	**Dr Sudheer Talari**	Provider Number:	**419100DJ**
Address line1:	**75 Murray Street** **Shop 1 Gawler SA 5118**	Email Address:	
Phone:	**85222294**	Signed:	**Dr Sudheer Talari**
Fax:	**85225777**	Completion Date:	**26/09/2025**

Printed and submitted on 26/09/2025 16:34:14 WCC No: 419100DJ-3001001931