**Australian Government crest, Department of Veterans' Affairs branding**

**DVA Rehabilitation Program Medical Certificate**

**Privacy Notice**

Your personal information is protected by law, including the *Privacy Act 1988*. Your personal information may be collected by DVA for the delivery of government programs for war veterans, members of the Australian Defence Force, members of the Australian Federal Police and their dependants.

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This form is used by DVA as evidence of a client’s capacity to undertake vocational rehabilitation activities, and their capacity to work.

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| --- | --- | --- | --- |
| **Client Details** | | | |
|  | | | |
| **Client Name** |  | | |
| **Date of Birth** |  | **REH Number** |  |

|  |
| --- |
| **Work Capacity Details** |

|  |  |
| --- | --- |
| **Q1: Does the client have capacity for some kind of work?** | Yes  No |
| **Q1a (i) If NO, please indicate the start and end date of the period of time that the client will not have capacity for some kind of work.** |  |
| **Q1a (ii) What specific condition, illness or injury is causing this incapacity?** | |
|  | |
| **Q1b (i) If YES, please indicate the types of work that would be suitable for the client to perform taking into account their conditions and limitations.** *Ie. Suitable Roles, industries, and/or work environments* | |
|  | |
| **Q1b (ii) What specific limitations does the client have in relation to the work they can perform?**  *Eg. Limitations with sitting, standing, lifting, walking, bending, etc.* | |
|  | |
| **Q1b (iii) What hours would the client be capable of working in a day and over the course of a week?**  *If the hours/days for which they are capable of working will change please advise these details.* | |
|  | |

|  |  |
| --- | --- |
| **Capacity to participate or engage in vocational rehabilitation** | |
|  | |
| **Q2: Does the client have the capacity to engage in vocational rehabilitation?** | Yes  No |
| **Q3: Does the client have the capacity to engage in a functional capacity evaluation/assessment?** | Yes  No |
| **Q4: Does the client have the capacity to engage in study or training?** | Yes  No |
| **Q4a What hours would the client be capable of studying or training in a day and over the course of a week?** | |
|  | |
| **Q4b Are there any factors to consider that may impact upon the client’s ability to study or participate in a training course?**  *ie. Psychological, medical, health related factors* | |
|  | |

|  |  |
| --- | --- |
| **Q5: Does the client have the capacity to engage in a Work Trial?** | Yes  No |
| **Q5a What hours would the client be capable of undertaking for a Work Trial in a day and over the course of a week?** | |
|  | |
| **Q5b Are there any psychological/medical/health related factors or limitations to consider that may impact upon the client’s ability to participate in a Work Trial?**  *Please note: This information will be used to inform the suitable duties devised for the Work Trial. Please ensure it is clear and comprehensive.* | |
|  | |
| **Q5c Are there any modifications or supports to a work environment or role that would be required for the client to successfully participate in a Work Trial?** | |
|  | |

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| --- | --- | --- | --- |
| **Medical/Health Practitioner Details** | | | |
|  |  |  |  |
| **Name** |  | | |
| **Profession/Speciality** |  | | |
| **Provider Number** |  | | |
| **Practice/Clinic Details** |  | | |
| **Signature** |  | **Date** |  |
| **Practitioner’s Stamp**  *Where applicable or available* |  | | |

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**Please return the completed form to the veteran or the DVA Rehabilitation consultant.**

**The consultant can return the form to DVA by uploading it to the Provider Upload Page (PUP).**

**Ensure ‘Medical Evidence’ is selected as the *document type* when uploading.**

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