

Medical or Dental Fitness Advice

• **Use only black pen and/or stamps**

<p>Medical facility</p> <hr/> <p>Member's unit</p> <hr/> <p>Date of attendance</p>	<p>Number</p> <hr/> <p>Rank</p> <hr/> <p>Family name</p> <hr/> <p>Given name(s)</p> <hr/> <p>Date of birth Sex</p>
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Part 1 (Completed by Health staff)

Injury (Tick appropriate box)

Work related Other

Date of injury	Is this an initial or continuing certificate
	Initial <input type="checkbox"/> Continuing <input type="checkbox"/>

Employment restrictions and other comments

Outcome (Tick appropriate box)		Dates inclusive:	
Full duty <input type="checkbox"/>	Restricted duty <input type="checkbox"/>	Number of days	From <input type="text"/> To <input type="text"/>
Discharged inpatient care <input type="checkbox"/>	Not fit for duty <input type="checkbox"/>	Number of days	From <input type="text"/> To <input type="text"/>
	Admitted to <input type="checkbox"/>	Institution <input type="text"/>	

Part 2 - Rehabilitation (MO to complete)

Does the member meet the Rehabilitation Enabling Criteria IAW DI(G) PERS 16-22		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes:		↓	
• MO to raise a Rehabilitation Assessment Referral	Referral completed	<input type="checkbox"/>	
• MO to inform member of the referral process	Completed	<input type="checkbox"/>	Not completed <input type="checkbox"/>

Part 3 - Recommendation and approval

Recommending Authority signature	Recommending Authority printed name	Rank or title	Date
Acknowledgement by unit (Signature)	Printed name	Rank or title	Date