Work Capabilities Checklist

Department of Education

Generic (other roles)

This form is to be completed by the employee's treating medical practitioner or allied health professional to provide information about the employee's current work capacity and functional abilities. The information will assist the Department of Education Queensland to support workplace rehabilitation and a safe return to work in accordance with departmental procedures. Before completing this form, please review the employee's role requirements using the resources below:

Role descriptions

Scan the QR code to access department standard role descriptions, which outline role duties and responsibilities.

Job Task Analysis (JTA)

Some role-specific JTAs are available via the QR code. Where unavailable, similar JTAs may provide information on comparable duties, tasks and work demands.

PRIVACY NOTICE: The Department of Education Queensland (the department) collects personal and relevant health information for workplace rehabilitation, injury management, return to work planning, and related employment purposes. Information may be used and disclosed to authorised department personnel and relevant third parties, including insurers, health providers and medical practitioners, where reasonably necessary for workplace rehabilitation and employment purposes. Information will not otherwise be disclosed without consent unless authorised or required by law.

Submission of this form to the department constitutes the employee's acknowledgement of this notice and consent to the collection, use, storage, and disclosure of personal information as described above.

Further information about the department's privacy policy is available at www.qed.qld.gov.au/privacy

Employee's name	
Role	
Work unit	
Diagnosis/condition	

Employee's capacity for work and duration *please provide the working days and number of hours the employee is fit for work*

The employee's pre-injury/substantive hours per week is _____ hrs

The employee is capable of performing the following duties and hours from ____/____/_____ to ____/____/_____

Is a graduated return to work recommended? No ☐ The employee is fit for full substantive hours

Yes ☐ Please complete the proposed graduated RTW plan below

Proposed graduated return to work plan	Hours per day	Days per week	Total hours per week	Comments
Week 1	hrs	days	hrs/wk	
Week 2	hrs	days	hrs/wk	
Week 3	hrs	days	hrs/wk	
Week 4	hrs	days	hrs/wk	

Estimated timeframe for return to full substantive hours and/or duties:

1 month ☐ 3 months ☐ 6 months ☐ 12 months ☐ More than 12 months ☐

Other ☐: _____ Permanently unable to resume full substantive duties ☐

Next medical practitioner review scheduled on ____/____/_____

Activity	Functional Capacity			Please provide further information to assist a safe, durable and sustainable return to work to undertake inherent duties of role *(e.g. Length of time task can be performed, any recommended aids/equipment/reasonable adjustments etc)*
	Capacity	No Capacity	Capacity with reasonable adjustment	
Please select applicable functions – blank fields indicate that limitations don't apply. Please include any impact of medications on function				
Physical				
Lifting – floor to waist	☐	☐	☐	No more than _____ Kg
Lifting – waist to shoulder	☐	☐	☐	No more than _____ Kg
Carrying/holding	☐	☐	☐	Using both hands, up to _____ Kg Using right / left hand only, up to _____ Kg *(Please circle relevant hand)*
Pushing/pulling	☐	☐	☐	No more than _____ Kg
Climb – steps/stairs/ladder	☐	☐	☐	
Sit	☐	☐	☐	Breaks: _____ minutes, every _____ hour(s)
Stand	☐	☐	☐	Breaks: _____ minutes, every _____ hour(s)
Walk	☐	☐	☐	
Kneel/squat	☐	☐	☐	
Bend/twist	☐	☐	☐	
Neck movement	☐	☐	☐	
Reaching – forward/side	☐	☐	☐	
Reaching – above shoulder	☐	☐	☐	
Wrist movement	☐	☐	☐	Using both OR right / left hand only *(Please circle relevant option/hand)*
Finger/thumb manipulation	☐	☐	☐	
Grip/grasp	☐	☐	☐	
Balance	☐	☐	☐	
Voice projection	☐	☐	☐	
Psychosocial				
Work at substantive location	☐	☐*	☐	
*If a temporary host placement is recommended, please outline reasons why the substantive location is medically unsuitable:				
Work in busy, fast paced environment	☐	☐	☐	
Exposure to traumatic and emotionally distressing situations	☐	☐	☐	
Work to required timeframes	☐	☐	☐	
Work autonomously	☐	☐	☐	
Work collaboratively as part of a team	☐	☐	☐	
Communication and interaction with others *(e.g. staff, students, parents, other stakeholders)*	☐	☐	☐	
Manage sensitive or confidential information	☐	☐	☐	
Negotiate challenging or confrontational situations	☐	☐	☐	

Participate in reasonable management action	☐	☐	☐	
Cognitive				
Attention/concentration	☐	☐	☐	
Memory *(short and long term)*	☐	☐	☐	
Judgement/decision making	☐	☐	☐	
Planning and organisation	☐	☐	☐	
Other possible role requirements				
Meet the required duty of care to provide a safe environment for students *(if relevant)*	☐	☐	☐	
Communication and interaction with students including managing student behaviour *(if relevant)*	☐	☐	☐	
Manage urgent responses to emergent situations *(e.g. critical incidents, urgent requests, changing priorities etc)*	☐	☐	☐	
Apply first aid *(if relevant)*	☐	☐	☐	
Respond to and support others, including individuals experiencing distress	☐	☐	☐	
Manage projects or activities with multiple stakeholders	☐	☐	☐	
Driving/travel *(if required)*	☐	☐	☐	
Complete training requirements relevant to specific role	☐	☐	☐	
Perform computer-based work *(e.g. typing, mouse, use systems etc)*	☐	☐	☐	
Participate in emergency procedures *(e.g. lockdowns, fire drills etc)*	☐	☐	☐	
Other:	☐	☐	☐	
Other:	☐	☐	☐	

Other considerations *Please address the information below to assist in supporting the employee's recovery and return to work.*	
Are there specific risks/considerations/barriers for the employee's recovery at work/return to work, identified by either yourself or the employee?	No ☐ Yes ☐ If Yes, please provide details:
Is the employee currently taking any medications that may affect their duties? If so, does the medication prevent them from enacting their duty of care to students and others and/or undertaking their duties which may include operating machinery, plant or equipment?	No ☐ Yes ☐ If Yes, please provide details:

Any additional comments / recommendations

I confirm that I have examined the employee, reviewed the relevant medical information and job task analysis and/or role description, and made an informed clinical assessment of their current work capacity. The recommendations and certification provided reflect my professional medical opinion based on the information available at the time of assessment. Work capacity may be subject to change and should be reviewed if the employee's condition or job requirements change.

Treating provider name			
Treating provider type *(e.g. General Practitioner, Physiotherapist)*			
Provider contact email			
Provider contact number		**Date completed**	_____ / _____ / _____
Treating provider signature		**Provider number/provider stamp**	

This Work Capabilities Checklist (WCC) was co-designed and developed by AXIS Rehabilitation in partnership with the Department of Education. This collaboration ensures the WCC is evidence-based, practical and aligned with workplace and organisational requirements, supporting informed decision-making in workplace rehabilitation, employment and safe work practices. The WCC provides a summary of work-related capabilities and may not capture every task, demand, or responsibility of a role. It should be considered alongside other relevant information, including workplace requirements and professional judgement.