SCHEDULE 2

AUTHORITY TO PROVIDE MEDICAL INFORMATION FOR FITNESS FOR WORK ASSESSMENT

To ....

Worker Details

Name ....

Date of birth ....

Address ....

Injury/illness ....

....

....

Employer's Details

Name ....

Contact name ....

Address ....

Email ....

Telephone ....

I authorise you to provide medical opinion and information as requested by my employer that is relevant to my injury/illness and my capacity for work.

Signed ....

Name ....

Date ....

DRAFT