Medical Certificate

Note: Please have your attending physician complete this form. Medical information provided is at the expense of the insured.

Policy Number	
Client	
Date of Birth	
Address	
ACC related ◯ Yes ◯ No	ACC number:
Diagnosis (causing work incapacity)	
Problem List (contributing to work incapacity)	
On what date will the client be fit to return to part-time or restricted work?	Date Capable hours
On what date will the client be fit to return to their normal work?	Date
If there are no fit to return to work dates, please list the tasks at the client's work they are able to do	
If there are no fit to return to work dates, please list the tasks at the client's work they are unable to do	
Are you completing any other medical certificates for this client? If so, please provide details	
Has the patient been hospitalised? If yes, please provide admission and discharge dates	
Is the client currently waiting on surgical intervention?	
Please provide details of any other relevant treatment providers for the client	

Any other comments or observations you would wish to make	

Attending Physician's declaration

I have personally examined the client named above today and to the best of my knowledge the information given above is accurate and correct.

Name			
Address			
Phone	( )		
Fax	( )		
Email			
Medical Specialty			
Signature		Date	/ /

If you have any enquiries about this form, please call 0800 123 642. Once completed please return to claims@nib.co.nz
Attention: Case Manager