

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 / /