

form for completion by a medical practitioner

MEDICAL CERTIFICATE

1) Name of the attending medical practitioner

Adress

Phone n° E-mail

2) Name of the claimant

Adress

3) Date of the incident / /

4) When did you first attend upon the claimant in consequence of the injuries sustained ? (date and hour) / / at . hrs

5) What injuries were sustained ? (regions injured / nature and extent of injuries)

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- Does it concern an acute traumatic injury ? yes no
- Is there an anamnesis ? yes no
- Could the injury be traceable to any other cause such as an accumulation of a serie of incidents/traumas or a predisposition ? yes no
- Observations :

6) Probable duration of the medical treatment

7) Will the claimant be unable to attend partially or totally to his usual business or occupation ? yes no
? · Totally during days.

· Partially during days.

8) Is there the necessity of a further examination by a specialist or an X-ray examination ? yes no
· If so, by whom ?

9) Will the incident cause a permanent disablement or may one expect a full recovery ?

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PREVIOUS MEDICAL HISTORY

10) Did the claimant at the time of the incident have any physical defect of infirmity or was he subject to or suffering from any illness of disease irrespective of his injuries ?

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11) Are you aware of anything in the claimant's previous medical history which might have contributed directly or indirectly to the occurrence of the incident or which may be likely to retard in any way his recovery from it (p.e. previous incidents or complaints i.r.o. similar injuries as those caused by the incident ?

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Could this incident possibly be a recurrence ?

Dated at

Signature and seal of the medical practitioner

On / /