



MEDICAL CERTIFICATION – FOR COMPLETION IN ALL CASES BY THE DOCTOR/DENTIS ONLY WHO ATTENDED THE CLAIMANT.

Cost of completion of the Medical Section of this claim form must be borne by the claimant

Web Reference

Patient's Name

Patient's Date of Birth

Address

Please state specific diagnosis

Cause of disability and details of treatment administered / prescribed

Date of diagnosis

Date patient first consulted you for this disability

Date from which unfit for work

Date fit to return to work (if known) If unknown, please give estimate

Has the claimant ever had this or a similar disability/treatment before? Yes No
If Yes, please give date and detail

Please Indicate if this injury is GAA related Yes No

Please indicate if the claimant has suffered an accidental bodily injury Yes No

Doctor's/Dentist's Declaration

I declare that to the best of my knowledge, the above information is accurate and correct and that the disability has been continuous as stated above.

Name (block capitals)

Signature

Telephone Number

Date

Stamp
(if no stamp available a business card or confirmation on the qualified practitioners headed paper must be submitted)