Medical Declaration Form

Medical Practitioner to Complete

The below responses are based on your professional opinion

Patient's Name		Date of Birth	

1. What is the medical condition debilitating the patient from work?

2. What treatment/medication is the patient currently receiving?

3. Do you believe the patient's condition is?	☐ Deteriorating	☐ Static	☐ Improving
4. If this condition is terminal, what do believe the patient's current life expectancy to be?			
5. Would the patient be fit to return to work on light duties, if available?	☐ Yes ☐ No	**Date**	
6. When do you believe the patient will be fit to return to work on full-time duties?		**Date**	
7. When did the patient last consult you for their condition?		**Date**	

8. Please list details below of all consultations the patient has attended you since the last Medical Declaration Form?

DATE ATTENDED	CONDITION FOR ATTENDANCE	TREATMENT/ADVICE GIVEN

9. Have any factors occurred that have prolonged the patient's recovery?

10. Do you believe the patient requires any of the below, in order to assist in a return to work? (please tick all applicable)

☐ Surgery ☐ Rehabilitation ☐ Physiotherapy ☐ Counselling ☐ Other, give details

11. Any additional comments (e.g. Return Work Plan, Surgery details)

I certify the above named patient is unfit for full duties for the period		**TO**	

Doctor's Declaration and Authority

I hereby certify that I am a registered medical practitioner and have examined the above named patient and that all information that I've supplied is true and correct. I also acknowledge that n2n Claims Solutions may provide copies of these forms to any required representative and/or third parties deemed necessary to assist in the ongoing assessment and management of the claim.

Practice/Hospital name			
Name (please print)			
Address			
Phone number		**Fax number**	
Email			
Signature		**Date**	

Medical Declaration Form

Member to Complete

1. Do you believe you are currently fit to return to full-time work?	☐ Yes ☐ No
2. If you believe you're fit to return to full-time work and have not returned, please give details why?	
3. When do you believe you will be fit to return to work on light duties? Date	
4. When do you believe you will be fit to return to work on full-time duties? Date	
5. Please advise the condition disabling you from returning to full-time work?	
6. Do you believe your condition is?	☐ Deteriorating ☐ Static ☐ Improving
7. Have you received any other income since your disablement commenced?	☐ Yes ☐ No
8. If "Yes", state the amount and when you received this? Amount	Date
9. What is your current work status? ☐ Employed ☐ Resigned ☐ Terminated	Date Ceased
10. Is there anything you believe we can do to assist you in your recovery to return to work?	☐ Yes ☐ No
11. Do you believe you require any of the below, in order to help you return to work? (please tick all applicable)	
☐ Surgery ☐ Rehabilitation ☐ Physiotherapy ☐ Counselling ☐ Other, give details	
12. Have you been reviewed by or referred to a Specialist?	☐ Yes ☐ No
13. If "Yes", please provide their contact details	
14. List details below of all attended and upcoming appointments, new tests, prescribed medication or surgery since last informing us?	

DOCTORS/SPECIALIST NAME	APPOINTMENT DATE	REASON ATTENDED (Type of tests, medication, surgical procedure etc.)

Member's Declaration and Authority

I hereby certify that all information I've supplied is true and correct. I also acknowledge that n2n Claims Solutions may provide copies of these forms to any required representative and/or third parties deemed necessary to assist in the ongoing assessment and management of the claim.

Your Name		Date of Birth	
Claim Number		Phone Number	
Postal Address			
Signature		Date	