

**PRIVATE AND CONFIDENTIAL  
MEDICAL CERTIFICATE TO BE COMPLETED BY INSURED PERSON'S DOCTOR**

I certify that Mr/Mrs/Ms \_\_\_\_\_ was

injured on \_\_\_\_\_

His/Her injuries are \_\_\_\_\_

Is the claimant suffering from any other conditions which might affect his/her recovery? If yes, state what they are.

\_\_\_\_\_

Are you the claimant's usual medical attendant? How long have you been so?

\_\_\_\_\_

What treatment, medication or therapy has been prescribed?

\_\_\_\_\_

Do you envisage the need to refer the claimant to a specialist? If yes, who and when?

\_\_\_\_\_

Are you aware of anything in the claimant's previous history which may delay his/her recovery?  
If yes, please give details

\_\_\_\_\_

He/She is solely and directly totally/partially disabled as a result of the injuries and will be so disabled until (period);

\_\_\_\_\_

Please state the basis of awarding incapacity after the disablement had been stabilized and no further improvement or deterioration is likely in the future.

\_\_\_\_\_

Signature and Qualifications \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

E-mail address \_\_\_\_\_

Clinic or Hospital Stamp \_\_\_\_\_

Telephone numbers \_\_\_\_\_

**Total Disablement is defined as a temporary but total and continuous disablement which prevents the insured member from the date of accident to perform any duty pertaining to his or any occupation.**

**Partial Disablement is defined as partial disablement which prevents the insured member from performing all duties pertaining to his occupation but is on light duties from date of accident.**