MEDICAL CERTIFICATION – FOR COMPLETION IN ALL CASES BY THE DOCTOR/ DENTIST 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? If Yes, please give date and detail Yes ☐ No ☐

Please Indicate if this injury is GAA related 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)