No claim can be admitted unless a medical certificate is furnished at the expense of the claimant.

MEDICAL CERTIFICATE OF TREATMENT

Note: This form is to be completed by the Claimant's Medical Attendant whose replies should be as complete and accurate as possible.

1) Name of Patient:	Name of Employee / Member's Company:
2) Diagnosis of illness or extent of injury. What are the complaints or physical findings?	What is the cause of the illness / injury?
3) Is the condition due to pregnancy, infertility or childbirth? ☐ Yes ☐ No	If yes, please specify the condition and the approximate date of commencement.
4) Is the condition a congenital anomaly or a physical defect present at birth?	☐ Yes ☐ No Date of Birth:
5) Is the condition a nervous mental disorder?	☐ Yes ☐ No
6) Please specify the approximate date of discovery of the illness or injury. Date:	How long was the illness / injury existing prior to the patient consulting you?
7) Did the patient have any symptoms prior to consulting you? ☐ Yes ☐ No If "Yes", please state the date the symptoms first started. Date:	When did the patient first consult you for this condition? Date:
8) Has the patient ever had the same or similar condition? ☐ Yes ☐ No ☐ Not to my knowledge	If "Yes", provide details, and state name and address of other consulting doctors.
9) Was the patient referred by any doctor to consult you? ☐ Yes ☐ No	If "Yes", state name and address of referring doctor.
10) Describe the surgical procedures or treatment rendered.	State the date the surgical procedures or treatment were rendered. Date: Is the surgery for cosmetic reasons? ☐ Yes ☐ No Is the surgery medically necessary? ☐ Yes ☐ No
11) Name of Surgeon / Anaesthetist:	In-patient or Out-patient medical treatment? _____________ Admission period: ______________ to _______________
12) Is the patient still under your care for this condition? ☐ Yes ☐ No	If "No", state the date the patient last consulted you. Date:

____
Signature of Physician / Surgeon

____
Date

____
Name and Title

____
Name and Address of Clinic / Hospital