MEDICAL CERTIFICATE OF DISABILITY FOR SUBMISSION

TO THE FUND BY THE APPLICANT'S MEDICAL PRACTITIONER

PORTION A:

Particulars of Employee (To be completed by employee's supervisor)

1. Initials and Surname_____

2. ID Number_____ 3. Pension Number_____

4. Designation_____

5. Employing Local Authority_____

6. Principal functions of employee's present occupation

_____

_____

_____

PORTION B:

Medical Report (To be completed by employee's medical practitioner)

It will be appreciated if you complete this portion of the form.

1. Full particulars of the employee's illness or disability.

_____

_____

_____

2. Full particulars of any remedial action by yourself or other medical practitioners regarding the above illness: (Specialist reports can be attached)

_____
_____
_____

3. In what respect and to what extent does the employee's state of illness hinder him in the performance of his daily duties as described in Portion A?

_____
_____
_____

4. Is the employee permanently unable to practice his regular occupation? Yes ☐ No ☐

If no, provide details.

_____
_____
_____

5. Was the illness/disability through the employee's own fault or caused by his behaviour?

Please provide details. Yes ☐ No ☐

_____
_____
_____

Signed at_____ on the_____ day of_____20 _____

_____ _____

SIGNATURE OF MEDICAL PRACTITIONER SIGNATURE OF WITNESS