

## Medical Certificate

For Compulsory Third Party (CTP) Insurance Claims  
to be completed by a Medical Practitioner

For information on the ACT Compulsory Third Party Scheme phone NRMA Insurance on (02) 6240.4700

### Claimant's Information

Claimant's Surname/Family Name	Given Names	Date of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

### Medical Information

Date of Accident	Date of Initial Examination	Are the injuries/conditions consistent with the circumstances of the motor accident described to you?	£ Yes	£ No
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>			

Description of Injury / Diagnosis

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

Clinical Findings (symptoms, results of any investigations and details of treatment/rehabilitation to date)

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

How long have you known this patient?

<input type="text"/>
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Has the patient had a similar condition?

<input type="text"/>
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Did the patient require an ambulance?

£ Yes	£ No
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Did the patient attend hospital?

£ Yes	£ No
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If admitted to hospital, was it more than 1 day?

£ Yes	£ No
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Name of Hospital

<input type="text"/>
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Date of first attendance at hospital

<input type="text"/> / <input type="text"/> / <input type="text"/>
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Will further treatment or therapy be required?

£ Yes	£ No
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Date patient was discharged from hospital

<input type="text"/> / <input type="text"/> / <input type="text"/>
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Details of Treatment, Medication and / or Therapy Necessary or Likely


Referred to:	Type	Name of Person	Phone Number or Contact Details
<input type="checkbox"/> Specialist			
<input type="checkbox"/> Therapist			
<input type="checkbox"/> Other			

Describe the patient's fitness for work	Date of Next Medical Review
<input type="checkbox"/> Fit to resume normal duties      Date:    /    /	/    /
<input type="checkbox"/> Certified fit for alternative duties.    Date from:    /    /    to    /    /	
<input type="checkbox"/> Certified unfit for work.                    Date from:    /    /    to    /    /	

**Medical Practitioner's Information**

Name (please print)	Provider Number
<input style="width: 100%;" type="text"/>	<input style="width: 100%; text-align: center;" type="text" value="/"/>

Practice Name and Address/Hospital Name

Telephone Number	Professional Qualification
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

I declare that I am a registered medical practitioner and to the best of my knowledge the information provided here is true and correct.

Signature	Date
<input style="width: 100%;" type="text"/>	<input style="width: 100%; text-align: center;" type="text" value="/    /"/>