THE NATIONAL INSURANCE BOARD EMPLOYMENT INJURY BENEFIT FOLLOW-UP MEDICAL CERTIFICATE

(Please use Block Capitals)

WARNING! Pursuant to Section 33 of the National Insurance Act, a person who makes any false statement is liable on summary conviction to a fine of \$3,000.00 and to imprisonment for two years.

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two years.	
SECTION "A" - TO BE COMPLETED BY APPLICANT	
I, SURNAME OTHER NAMES follow-up Medical Certificate at Section "B" being submitted to the National Insurance Board.	hereby consent to the
NATIONAL INSURANCE NO.	
NAME OF EMPLOYER:	
I declare that I have not worked as a result of my injury and that the information given is true and correc	t.
DATE: SIGNATURE OR MARK OF APPLICANT	YYYY MM DD
PARTICULARS OF WITNESS TO MARK (WHERE CLAIMANT CANN	IOT SIGN)
NAME: OCCUPATION:	
IDENTIFICATION (Tick Ap	propriate Box):
ADDRESS:	VER'S PERMIT ELECTORAL I.D.
PASSFORT DIN	VER 3 PERIVIT
NUMBER:	
SIGNATURE OF WITNESS TO MARK	YYYY MM DD
SECTION "B" - TO BE COMPLETED BY MEDICAL PRACTITIONER	
I hereby certify that Mr/Mrs/Ms SURNAME	OTHER NAMES
was examined by me on and found the following injuries/industr	ial disease ——————————————————————————————————
	which is/is not consistent
with an accident sustained at work on YYYY MM DD - An examination on	YYYY MM DD
shows that he/she is still unfit for work as a result of the injury. I hereby recommend that the patient is fit to	resume duties/should be granted a
a further with effect from Y Y Y N	/ M D D
NAME IN BLOCK LETTERS OR STAMP OF DOCTOR:	TELEPHONE NO:
ADDRESS:	
DATE:	
SIGNATURE OF DOCTOR	YYYY MM DD

NOTE: National Insurance Legislation 980 provides that Employment Injury Benefit may be paid for a maximum of 52 weeks. At the end of the injury leave period the insured person's extent of disability as a result of the accident is assessed to determine eligibility for Disablement Benefit.

SE	ECTION "C" - FOR USE BY EMPLOYER
	INSTRUCTIONS FOR COMPLETION This Section must be completed by the Employer before the Employment Injury Benefit application is submitted to the Board.
1.	EMPLOYER'S NAME:
	REGISTRATION NO.:
2.	This is to certify that during the period recorded at Section "B" of this form, Mr/Mrs/Ms SURNAME OTHER NAMES
	from work as a result of an accident/industrial disease developed on the job on
	NOTE: If the Injured Person worked during this period, please state the period worked.
	YYYY MM DD YYYY MM DD
3.	Have you paid any of the related medical expenses? YES NO If "YES", please state the details of the services paid for.
	EMPLOYER DECLARATION
:	WARNING! Pursuant to Section 33 of the National Insurance Act, a person who makes any false statement is liable on summary conviction to a fine of \$3,000.00 and to imprisonment for two (2) years. I declare that the information given is true and correct.
	NAME: SURNAME OTHER NAME(S) SIGNATURE:
	POSITION: (If any)
SE	CTION "D" - FOR OFFICIAL USE
DE	TERMINATION
1. (a	a). WEEKLY RATE OF BENEFIT IN CLASS
(t	Payment is approved and authorised for the period YYYY MM DD YYYY MM DD
	in Class at the Rate of \$ per Week.
2	[See Medical Adviser's response at Minute () and parent claim at folio ()]. Payment is NOT approved on the grounds that:
DE	CISION/AUTHORISATION:
Αį	oplicant notified of decision on Form NI 44/NI 53 dated YYYY MM DD
De	ecision recorded on I. A. system YYYY MM DD
_ SI	GNATURE OF MGR./SUPERVISOR/C.O. II DATE: YYYY M M D D