THE NATIONAL INSURANCE BOARD

MEDICAL REPORT — DISABLEMENT BENEFIT

N.I. NUMBER								

NAME:..

ADDRESS:..

DATE OF BIRTH		

....

PART I — DETAILS OF INCAPACITY AND MEDICAL CERTIFICATION

(To be completed by the N.I.B.)

The above has been certified incapable of work due to Employment Injury/Prescribed Disease from

Day	Mth	Yr.	to	Day	Mth.	Yr.

The nature of the incapacity is stated on the copy/copies of the medical certificate(s) contained in the claimant's file.

PART II — MEDICAL REPORT *(To be completed by the Medical Practitioner)*

1. Full clinical description of the claimant's present condition:..

....

....

....

....

2. I am of the opinion that:

(i) This claimant has suffered a loss of faculty as a result of Employment Injury/ Prescribed Disease No. ....

(ii) The extent of disability is assessed at.. *(In words and figures)*

(iii) The disability will persist for a period of...............................*days/weeks/months/permanently, with effect from [| |] *(In words and figures)*

(iv) This claimant is/is not* in a position to travel on his/her own.

3.. Additional remarks by Medical Practitioner.

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....

....
Date

....
Signature of Medical Practitioner

*Delete where applicable

NIB/GS: 10/87