MEDICAL CERTIFICATE

SOVEREIGN

To be completed by the client's attending physician at the client's expense

Policy Number

Client

Date of Birth

Address

Pre-Disability Occupation

Pre-Disability Hours Worked

Diagnosis
(causing work incapacity)

Problem List
(contributing to work incapacity)

On what date will the client be fit to return to part-time or restricted work?

Date

Capable hours

On what date will the client be fit to return to their normal work?

Date

If there are no fit to return to work dates, please list the tasks at the client's work they are able to do

If there are no fit to return to work dates, please list the tasks at the client's work they are unable to do

Are you completing any other medical certificates for this client? If so, please provide details

Please list medications and dosages

Please list diagnostic investigations undertaken since the last medical certificate

Please provide details of any other relevant treatment providers for the client

SOVEREIGN

Other questions

Case Manager to complete as relevant

Any other comments or observations you would wish to make

Would you like a Sovereign Medical Advisor or Case Manager to phone you to discuss this case? (you are able to invoice Sovereign reasonable costs for this discussion)

☐ Yes ☐ No

Best day to call

Best time to call

Home ( )

Attending Physician's declaration

I have personally examined the client named above today and to the best of my knowledge the information given above is accurate and correct.

Name

Address

Phone ( )

Fax ( )

Email

Medical Specialty

Signature

Date / /