

ASR number:.....
(to be stated if the notification is made electronically)

EMPLOYER.....

POLICY NO.....

MEDICAL CERTIFICATE

(1) Surname, first name(s), capacity, address.

The undersigned (1).....

(2) Surname, first name(s), address of the person concerned.

has examined (2).....

after the accident he/she had on date and time

and declares

(3) State: the type and the nature of the injuries and the parts of the body concerned (broken arm, bruising to head or finger, internal injury, asphyxiation, etc.).

1. that the accident caused the following injuries (3):

2. that the injuries have (will have) the consequence (4):

(4) The certain or probable consequences of the injury established: death, full or partial permanent disability, full or partial temporary disability, with indication of the probable duration of the temporary disability.

3. that the disability started (will start) on (5):

(5) The doctor must establish whether the disability normally results from the injury itself, without taking account of any other circumstances whatsoever.

4. that the person concerned is cared for at (6):

(6) State where the person concerned is being cared for.

Drawn up in on

The doctor,
(signature)