Section B – Doctor's Statement **(Must be completed by your regular Treating Doctor)**

Please note any and all charges for the completion of this form is the full responsibility of the patient.
It may also be helpful with the assessment and ongoing management of this claim if you can supply any additional reports, clinical notes etc.

Patient's Details

Patient's name					
Patient's address					
Suburb		**State**		**Postcode**	
Gender		**Date of birth**		**Age**	

Are you the patient's regular Doctor?	☐ **Yes** ☐ **No**	**How long has this patient been attending your practice/hospital?**	
The medical condition currently disabling the patient from work is an	☐ **Injury** **OR** ☐ **Sickness**		
When did the patient first attend your practice for the current condition?	**Date**		
What date did the patient's symptoms first appear or injuries occur?	**Date**		
When was the patient diagnosed?	**Date**		
What date was the patient incapacitated from work for this condition?	**Date**		

For this condition, please list all dates the patient attended your practice/hospital for treatment and advice. If insufficient space, please provide additional report

1.		**2.**		**3.**		**4.**		**5.**	
6.		**7.**		**8.**		**9.**		**10.**	
11.		**12.**		**13.**		**14.**		**15.**	

Please state the primary medical diagnosis disabling the patient

If any, please list all other medical conditions affecting a return to work

What was the event / cause of the patient's current disablement?

Please provide details of the patient's symptoms

Please advise the prescribed medication and treatment given to the patient

Are there any complications regarding the patient's recovery?	☐ **Yes** ☐ **No**
If "Yes", please give details	
In your professional opinion, do you believe this condition is work related?	☐ **Yes** ☐ **No**
In your professional opinion, do you believe this condition is sports related?	☐ **Yes** ☐ **No**
In regards to the patient's medical condition, have you issued any certificates or forms to any other insurance companies, workers compensation or government benefit entities?	☐ **Yes** ☐ **No**
If "Yes", please advise to which company	

Has the patient had a similar condition in the past?		☐ Yes ☐ No	If "Yes", please provide details below
Medical condition was		Onset of the condition occurred	
DOCTOR'S NAME	PRACTICE/HOSPITAL NAME	CONTACT NUMBER	DATE ATTENDED
Has the patient been following your prescribed medication and treatment?		☐ Yes ☐ No	
If "No", give details of when the patient did not follow the medical advice			
Have you advised the patient that their condition no longer requires any treatment or advice?		☐ Yes ☐ No	
If "Yes", please advise the date you gave this advice to the patient			
Has the patient been referred to a specialist for the condition?		☐ Yes ☐ No	
If "Yes", please give contact details			
Does the patient require surgery?	☐ Yes ☐ No		
What surgery was/is required?			
If "Yes", has surgery occurred?	☐ Yes ☐ No	When was/is surgery?	
If "No", surgery waiting list type	☐ Public ☐ Private	Waiting list Category or Timeframe	
Have you been provided with a copy of the patient's job description outlining their occupational duties?			☐ Yes ☐ No
In your professional opinion, when do you believe the patient will be fit to return to work on alternative duties?			
In your professional opinion, when do you believe the patient will be fit to return to work for full duties?			
Please comment on the patient's current prognosis			
I certify the above patient was/is TOTALLY DISABLED from returning to work for the period		TO	
I certify the above patient was/is PARTIALLY DISABLED from returning to work for the period		TO	

Doctor's Declaration and Authority

I hereby certify that I am a registered medical practitioner and have examined the above named patient and that all information that I've supplied is true and correct. I also acknowledge that WIP may provide copies of these forms to any required representative and/or third parties deemed necessary to assist in the ongoing assessment and management of the claim.

Practice/Hospital name					
Name (please print)					
Address					
Suburb		State		Postcode	
Phone number		Fax number			
Email					
Medical qualifications					
Signature		Date			