1st Floor,
33 George Street, Launceston
PO Box 590, Launceston 7250
DX 70112, Launceston
Telephone: (03) 6336 4800

TOLL FREE 1800 006 224

Facsimile: (03) 6336 4848
Email: info@maib.tas.gov.au
Website: www.maib.tas.gov.au

CLAIM NUMBER _ _ _ _ _ _ _ _ _ _

Medical Certificate

FORM J

To be completed by Medical Provider

(Please print neatly in BLOCK LETTERS and use a BLACK or DARK BLUE pen)

This certificate must only be used in respect of patients for whom you have provided treatment for injuries resulting from a motor accident, and who, in your opinion, may qualify for any or all of the following:

- Housekeeping Assistance
- Transport Assistance
- Claim for Loss of Income

Sections A and B must be completed, with sections C, D & E only where relevant.

Section A: Medical Practitioner's Details

Name of Medical Practitioner completing this Certificate		Provider Number
Name of Medical Practice/Hospital		
Address of Medical Practice/Hospital		
	State	Postcode
Contact Numbers: Telephone		Facsimile

Section B: Patient's Details

Full Name of Patient	
Date of Birth	/ /
Date of Accident	/ /
I examined the patient on the	/ /

and found the patient to have the following injuries:

The patient stated the above injuries were allegedly caused by:

These injuries are:

- ☐ Consistent with the stated cause
- ☐ Inconsistent with the stated cause
- ☐ An aggravation of an existing condition
- ☐ A recurrence of a previous condition

Section C: Loss of Income

I consider the patient to be

☐ Wholly disabled, as a result of the injuries sustained, from engaging in his/her usual employment or occupation

For the period / / to / /

and/or

☐ fit to return to modified duties for ..... hours per week

For the period / / to / /

with the following restrictions:

The patient is expected to be fit for pre-injury employment on / /

Section D: Transport Assistance

To assist people with serious injuries, particularly in the acute state of injury.

It is my opinion that, given the patient's injuries, taxi transport is required. I recommend that the MAIB consider the payment of taxi fees to and from medical treatment.

Treatment	
Provider Name	
Address	
Frequency	

For the period / / To / /

Section E: Housekeeping Assistance

It is my opinion that the injuries sustained render the patient wholly disabled from carrying out their NORMAL household duties. I recommend that the patient receive assistance in the following duties.

1.	4.
2.	5.
3.	6.

The patient will require assistance in the carrying out of these duties for hours per week

For the period / / To / /

Section F: Additional Requirements/Comments

(i.e. requires physiotherapy, rehabilitation service provider, equipment, Medication Required as a Result of Accident, etc.)

Signature of Medical Practitioner

Dated / /

PATIENT'S AUTHORITY

I authorise release of this information and certificate to the Motor Accidents Insurance Board, or its agent.

Signature of patient, or representative acting on behalf of patient.