

Medical Certificate

This Medical Certificate is to accompany your Notice of Accident Claim Form and must be completed by a medical practitioner.
For information about Queensland's Compulsory Third Party (CTP) insurance scheme and completing the Medical Certificate, phone the MAIC Enquiry line on 1300 302 568 or visit maic.qld.gov.au/for-health-providers/providing-medical-certificates.

Injured person

Surname/family name

Given name/s

Date of birth

DD/MM/YYYY

Medical information

Date of accident

DD/MM/YYYY

Date of initial examination by a doctor

DD/MM/YYYY

Did you physically examine the injured person?

 Yes No

▶ If yes, on what date?

DD/MM/YYYY

Are the injuries/conditions consistent with the circumstances of the motor accident described to you?

 Yes No

Was the injured person an existing patient of yours, or your medical practice, as at the date of the accident?

 Yes No

Medical diagnosis and description of injury

Clinical findings (symptoms, results of any investigations, and details of treatment/rehabilitation to date)

Was the injured person treated at a hospital?

 Yes No

Name of hospital

If the injured person was admitted to hospital, was it for longer than 24 hours?

 Yes No

Did the injured person require an ambulance?

 Yes No

I am a registered medical practitioner and to the best of my knowledge the information provided here is true and correct.

Initial of medical practitioner

Proposed treatment plan

Treatment likely to be required

<input type="checkbox"/> Nil	<input type="checkbox"/> Short term (<6 weeks)	<input type="checkbox"/> Medium term (6 – 12 weeks)	<input type="checkbox"/> Long term (>12 weeks)
------------------------------	--	--	--

Details of treatment plan (including recommendations and advice to patient)

Referred to	Type	Name of person/practice	Best contact number
<input type="checkbox"/> Specialist			
<input type="checkbox"/> Therapy			
<input type="checkbox"/> Other			

Describe the injured person's fitness for work

<input type="checkbox"/> Fit to resume normal duties on	/ /
	DD/MM/YYYY

Date of next medical review

/ /
DD/MM/YYYY

<input type="checkbox"/> Fit for alternative duties on	/ /
	DD/MM/YYYY

<input type="checkbox"/> Unfit for work from	/ /	to	/ /
	DD/MM/YYYY		DD/MM/YYYY

Medical practitioner's information

Medical practitioner's name	Professional qualification

Medicare provider number	AHPRA registration number

Telephone number	Hospital/practice name
()	

Email address

Hospital/practice address (include unit number (if applicable), street number and street name)

	Street type	
Suburb/town	State	Postcode

I declare that I am a registered medical practitioner and to the best of my knowledge the information provided here is true and correct.

Signature

Date
/ /
DD/MM/YYYY