Please return to:
Calliden Insurance
PO Box 348
Milsons Point NSW 1565 Australia
Phone: 1300 880 037 (option 2)
Fax: (02) 9551 1010
Email: claims@calliden.com.au

MEDICAL ASSESSMENT CERTIFICATE

TO BE COMPLETED BY A QUALIFIED MEDICAL PRACTITIONER AT NO EXPENSE TO THE INSURER

(Please print clearly)

1. Full name of insured: .....
2. Date of birth: .....
3. Full address: .....
4. a) Disability – please state in full, description of illness or injury suffered: .....

   .....

   .....

   b) Date of Accident causing Disability: .....
5. Illness – please state the date of origin of this illness: .....

   .....

   After my examination and taking into consideration the following definitions, I assess his/her disability level as follows:

6. TOTAL WORK DISABILITY (TOTALLY DISABLED)

   Definition: Means the inability as a direct result from the injury or illness to engage in, perform or attend to his/her nominated occupation/s. The ability to only perform intellectual and/or supervisory duties not of a physical nature will constitute total disablement.

   I assess the patient will be totally disabled from ..... to .....

7. SUBSTANTIAL WORK DISABILITY (PARTIAL – LIGHT DUTIES)

   Definition: Means the inability as a direct result from the injury or illness to engage in, perform or attend to a SUBSTANTIAL part of his/her nominated occupation/s but WHILST ABLE TO ATTEND TO LIGHT DUTIES

   I assess the patient will be partially disabled from ..... to .....

8. The patient is fully fit for work on .....
9. General: I believe that the following specialist treatment could assist the recovery and/or rehabilitation of the patient:

   .....

   .....

   .....

FINAL CERTIFICATE/ FURTHER REVIEW REQUIRED (please circle one)

I hereby certify the statements are true and correct.

Doctor's name: .....

Qualifications: .....

Address: .....

Phone number: .....

Signed: .....

Date: .....