MEDICAL CERTIFICATE

To be FULLY completed by the doctor at the member's request

NAME and SURNAME of the patient: ----------

His/her member reference number: ----------

REASON FOR HOSPITALISATION OR TREATMENT:

Date of admission: ----------

Type of hospitalisation: ----------

Nature of illness: ----------

Treatment received: ----------

Date illness diagnosed: ---------- / ---------- / ----------

Date first symptoms appeared: ---------- / ---------- / ----------

Medical history of illness (if applicable): ----------

Is the hospitalisation linked to an accident? ---------- / Date of accident: ----------

Nature and circumstances of accident: ----------

Injuries sustained: ----------

Has the illness prevented the patient from working? ----------

If so, date stopped work and how long expected to be off work for: ----------

Produced on the ---------- / ---------- / ---------- and given to the patient

Doctor's signature and stamp

This certificate can be sent in a sealed envelope marked 'Private & Confidential' for the attention of the Insurer's Consulting Doctor