

# 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: -----

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Treatment received: -----

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

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

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

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

Nature and circumstances of accident: -----

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Injuries sustained: -----

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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*