Medical Certificate

For Compulsory Third Party (CTP) Insurance Claims
to be completed by a Medical Practitioner
For information on the ACT Compulsory Third Party Scheme phone NRMA Insurance on (02) 6240.4700

Claimant's Information

Claimant's Surname/Family Name	Given Names	Date of Birth
		/ /

Medical Information

Date of Accident	Date of Initial Examination		
/ /	/ /	Are the injuries/conditions consistent with the circumstances of the motor accident described to you?	☐ Yes ☐ No

Description of Injury / Diagnosis

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

How long have you known this patient?

Has the patient had a similar condition?

Did the patient require an ambulance?	Did the patient attend hospital?	If admitted to hospital, was it more than 1 day?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Name of Hospital	Date of first attendance at hospital
	/ /

Will further treatment or therapy be required?	Date patient was discharged from hospital
☐ Yes ☐ No	/ /

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Details of Treatment, Medication and / or Therapy Necessary or Likely

Referred to:	Type	Name of Person	Phone Number or Contact Details
☐ Specialist			
☐ Therapist			
☐ Other			

Describe the patient's fitness for work	Date of Next Medical Review
☐ Fit to resume normal duties Date: / /	/ /
☐ Certified fit for alternative duties. Date from: / / to / /	
☐ Certified unfit for work. Date from: / / to / /	

Medical Practitioner's Information

Name (please print)

Provider Number

/

Practice Name and Address/Hospital Name

Telephone Number

Professional Qualification

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

/ /

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