Level 9 FNPF Place, 343 – 359 Victoria Parade, Suva Ph. (679) 330 2717 Fax. (679) 330 2119

MEDICAL ATTENDANT'S STATEMENT
(In conjunction with a Total and Permanent Disablement Claim)

Patient's Name	Mr/Mrs/Ms
Occupation	

1. (a) How long has the claimant been your patient? (b) If claimant was referred to you, please give the name and address of the referring doctor.	(a) (b)
2. (a) Please describe the nature and extent of his/her sickness or injury. (b) Has the patient suffered from this or a similar condition previously? If 'Yes' please provide details	(a) (b) Yes No
3. (a) When were you first consulted for this disability? (b) Please provide dates of all other consultations for the disability. (c) Is the patient still receiving treatment for the disability?	(a) / / (b) (c)
4. (a) If an x-ray examination has been made, please state findings and/or radiologist's report (b) If any other tests have been done, please state type and results.	(a) (b)
5. What are the details of treatment currently prescribed? (Please include the names and dosages of any drugs).	
6. Do you consider any treatment, other than that currently being administered necessary for recovery? If so, please comment.	Yes No
7. (a) If hospitalization was required, name and address of hospital. (b) What was the period of hospitalization?	(a) (b) From ……./… …/……. To ……./… … ./… ….

(c) If a surgical procedure was performed, please give details and nature of the surgery.	(c)
8. Are there any complications hindering recovery from this disability? If 'Yes' please provide details.	Yes No
9. Have you issued any other certificates concerning the patient's disability? If 'Yes', for what purpose?	Yes No
10. In your opinion as a result of this disability, is the patient rendered incapable of working at his/her normal occupation or to one that he/she would be fitted to by education, training or experience. If 'Yes' in your opinion, is the disablement permanent in that the patient will never be able to return to any such occupation? Please provide the date that total disablement commenced.	Yes No From ……../……/……..

ADDITIONAL REMARKS AND PROGNOSIS

Please comment on any special matters which lead you to your answers in question 10.

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I certify that I have personally attended the above-named patient and that the provided Statement is correct.

Signature: …… Qualifications: ……

Name: *(please print)* ……

Address: ……

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Telephone: …… Date: ……/……/……..

(Any charge for this statement must be borne by the patient).