|  |  |
| --- | --- |
| **Medical certificate of incapacity to work for the attention of the life insurers’ consulting doctor** | Policy no./Contract no./OASI no.:     Start of incapacity to work:      [ ]  Disease [ ]  Accident |
|  |  |
| **1. Patient** |

|  |  |
| --- | --- |
| First name:      Date of birth:      Address:       | Surname:      Sex:  |

 |
|  |  |
| **2. Occupation** |

|  |  |
| --- | --- |
| Current occupation(s):      | Workload:     hours/day     days/week[ ]  Employee [ ]  Self-employed[ ]  Currently not employed |

 |
|  |  |
| **3. Treatment** | Outpatient treatment with you since:       until:      Previous outpatient treatment by (name, address, speciality and duration):

|  |
| --- |
|       |

Follow-up outpatient treatment by (name, address, speciality and duration):

|  |
| --- |
|       |

Inpatient treatment: where?

|  |
| --- |
|       |

From when to when?      In the case of surgery, please provide details:      When and where?       |
|  |  |
| **4. Medical history** | a) When and how did the disorder first appear? |
|  |       |
|  | b) Subjective patient details: |
|  |       |
|  | c) Had the patient been treated for this disorder previously? [ ]  Yes [ ]  No |
|  |

|  |
| --- |
| If so, where?       |

When?        |
|  | d) Previous therapies: |
|  |       |
|  | e) Are there any pre-existing illnesses and/or consequences of accidents? [ ]  Yes [ ]  No |
|  |

|  |
| --- |
| If so, please provide details:       |

Since when?      Who was the consulting doctor/hospital?

|  |
| --- |
|       |

Are they affecting the healing process? [ ]  Yes [ ]  No

|  |
| --- |
| If so, to what extent?       |

 |
|  |  |
| **5. Objective** **findings** | Examinations, findings of imaging tests, explanations and discharge reports (please provide copies): |
|

|  |
| --- |
| Please provide details:       |

Date:       |
|  |  |
| **6. Diagnosis** | ICD code and differential diagnosis, if applicable: |
|  **with**  an impact on capacity to work |       |
|  **without**  an impact on capacity to work |       |
|  | Objective restriction on current activities: |
|  |       |
|  |  |
| **7. Other  factors** | Are there any factors that could have a negative impact on the healing process (e.g. working environment, social factors, commute to/from work, addiction)? [ ]  Yes [ ]  No |
|  | If so, please provide details:       |
|  |  |
| **8. Therapy** | a) Current treatment and medication (including dosage): |
|  |       |
|  | b) Procedure/suggestions (imaging diagnostics, examination by a specialist doctor, treatments, etc.): |
|  |       |
|  | c) Prognosis: |
|  |       |
|  |  |
| **9. Incapacity** **to work** | Manageableworkload:(% of usualworkload): | Manageablepresence at work(hours/day): | Incapacity to workas a %: | Incapacity to workfrom: | Incapacity to workuntil: |
|  |       |       |     |       |       |
|  |       |       |     |       |       |
|  |       |       |     |       |       |
|  |       |       |     |       |       |
|  | Return to work: planned from:       at     hours/day expected in:     weeks at     hours/day |
|  |  |
| **10. Reintegration** | a) Is another reasonable job/activity expected to be considered? [ ]  Yes [ ]  No |
|  | If so, which, and to what extent?       |
|  | b) Has a new job/activity been started recently? [ ]  Yes [ ]  No |
|  | If so, please provide details:       |
|  | c) Are there restrictions in the new job/activity? [ ]  Yes [ ]  No |
|  | If so, please provide details:       |
|  | d) From a medical point of view, is there a restriction on driving a vehicle? [ ]  Yes [ ]  No |
|  | If so, please provide details:       |
|  |  |
| **11. Consultations** | Date of last consultation      Date of next consultation       |
|  |  |
| **12. Other** **insurers** | Are other service providers involved (accident insurers, sickness benefit insurers, invalidity insurance, military insurance, etc.)? [ ]  Yes [ ]  No |
| If so, please provide details:       |
|  |  |
| **13. Remarks** |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Place and date:      |  | Doctor’s address:      |  | Doctor’s signature:  |