# 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: | Surname: |
|---|---|
| Date of birth: | Sex: |
| Address: | |

**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**

| Manageable workload: (% of usual workload): | Manageable presence at work (hours/day): | Incapacity to work as a %: | Incapacity to work from: | Incapacity to work until: |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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: |
| --- | --- | --- |
| | | |