Medical Certificate

This Medical Certificate is to accompany your Notice of Accident Claim Form and must be completed by a medical practitioner. For information about Queensland's Compulsory Third Party (CTP) insurance scheme and completing the Medical Certificate, phone the MAIC Enquiry line on 1800 CTP QLD (1800 287 753) or visit **maic.qld.gov.au/for-health-providers/providing-medical-certificates.**

Injured person

Surname/family name

Given name/s

Date of birth

/ /
DD/MM/YYYY

Medical information

Date of accident

/ /
DD/MM/YYYY

Date of initial examination by a doctor

/ /
DD/MM/YYYY

Did you physically examine the injured person? ☐ Yes ☐ No

▶ If yes, on what date? / /
DD/MM/YYYY

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

Was the injured person an existing patient of yours, or your medical practice, as at the date of the accident? ☐ Yes ☐ No

Medical diagnosis and description of injury

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

Was the injured person treated at a hospital? ☐ Yes ☐ No

Name of hospital

If the injured person was admitted to hospital, was it for longer than 24 hours? ☐ Yes ☐ No

Did the injured person require an ambulance? ☐ Yes ☐ No

I am a registered medical practitioner and to the best of my knowledge the information provided here is true and correct.

Initial of medical practitioner

Proposed treatment plan

Treatment likely to be required

☐ Nil ☐ Short term (‹6 weeks) ☐ Medium term (6 – 12 weeks) ☐ Long term (›12 weeks)

Details of treatment plan (including recommendations and advice to patient)

Referred to	Type	Name of person/practice	Best contact number
☐ Specialist			
☐ Therapy			
☐ Other			

Describe the injured person's fitness for work

☐ Fit to resume normal duties on / / DD/MM/YYYY

☐ Fit for alternative duties on / / DD/MM/YYYY

☐ Unfit for work from / / DD/MM/YYYY to / / DD/MM/YYYY

Date of next medical review

/ / DD/MM/YYYY

Medical practitioner's information

Medical practitioner's name

Professional qualification

Medicare provider number

AHPRA registration number

Telephone number

( )

Hospital/practice name

Email address

Hospital/practice address (include unit number (if applicable), street number and street name)

	Street type	
Suburb/town	State	Postcode

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

/ / DD/MM/YYYY