NBCRFLI
National Bargaining Council for the Road Freight and Logistics Industry
Your Road Freight Partner.

nmg BENEFITS

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Confidential medical report by attending physician

(To be completed by the attending physician) Section B

Tick ☑ where applicable Please use a black pen and block letters

Please note: If there is not enough space provided on the form, please continue on a separate sheet of paper.

Dear Member

Please have the disability claims package completed by your physician. You are required to pay the physician for completing the medical report/s.

NMG would prefer all medical reports to be completed by the attending specialist. In cases where a specialist is not consulted, a report from the attending general practitioner will be accepted. It is then more likely that additional medical reports will be requested.

Dear Doctor

NMG has received an application for a disability claim for this member and would appreciate you completing this confidential medical report. It is essential that you complete this form as fully as possible to prevent any unnecessary delays.

Please note: The cost of completing this medical report must be borne by the member.
If you have any reports of previous investigations to substantiate the diagnosis, please supply copies.
The request for completion of this form in no way constitutes an admission of liability by NMG.
If the claimant is only consulting a general practitioner, NMG suggests he consults a specialist at his/her nearest provincial hospital for completion of the forms where reports are to be completed by a specialist.

Purpose: To assess the member's impairment (medical assessment), and to ascertain;
- change in functional capacity due to illness or injury
- diagnosis
- optimal medical treatment

A. Member's personal details

Surname

First names

Member number Date of Birth Y Y Y Y M M D D

Identity number

Employer name

B. Impairment history

What is the member's Height cm Weight kg

When did the member first consult you? Y Y Y Y M M D D

On what date did the first symptoms of the condition claimed for appear? Y Y Y Y M M D D

If you are still attending to the member, when was the last consultation? Y Y Y Y M M D D

Please complete the schedule below.

Date	Reason for consultation	Diagnosis	Treatment	Result/prognosis

B. Impairment history (continued)

Have clinical investigations been performed to determine the condition? Yes ☐ No ☐

If "Yes", comment on the results of all tests/examinations performed to confirm diagnosis (please include copies)

How has the member's condition been treated over the past 12 months? (Discuss treatment regimen prescribed)

Date	Treatment (medication and dosage)	Outcome

Is future surgery/treatment planned? (if applicable) Yes ☐ No ☐

If "Yes", what type of surgery/treatment and when?

Notwithstanding the treatment regimen described above, and the envisaged cost thereof, what further treatment would you recommend to improve the member's condition and/or activities of daily living?

Please provide a full description of any related conditions that the member has

Please provide a full description of any related symptoms that the member has

Do you know of any other factors (e.g. previous illness or injury, hazardous pastimes or pursuits, habits or self inflicted injuries) that may have contributed in any way to the member's impairment? Yes ☐ No ☐

If "Yes", please comment fully.

In your opinion, when will the member be able to go back to work?

Part-time Date Y Y Y Y M M D D Duties

Full-time Date Y Y Y Y M M D D Duties

If the member has already recovered and returned to work, please give the date of his/her return to work Y Y Y Y M M D D

Please provide any additional information which you feel will assist NMG in the assessment of this claim (if there is not enough space provided on this form, please continue on a separate sheet).

Have you included copies of all tests and reports? Yes ☐ No ☐

Additional comments:

C. Details of medical practitioner

Doctor's name and address (please print)

Telephone no (code+number)

Fax no (code+number)

Cellular number

Practice number

E-mail address

Qualification

I declare and warrant that all the information provided by me in this confidential medical report is complete and true. I accept full responsibility for any inaccuracies or omissions contained in this confidential medical report and I understand that the insurer may bring criminal or civil charges against me in the event that any such inaccuracies or omissions are discovered by the insurer.

Doctor's signature

Date Y Y Y Y M M D D