**Section A:** To be completed by a Registered Medical Practitioner

1. In Confidence to:  
   - Mr. /  
   - Mrs. /  
   - Ms. 
   ![Image](image.png)

2. I certify that I examined you on ________________ and that in my opinion, you were incapable of working at the time of the examination.

3. **Diagnosis / Operation:**

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Description of Diagnosis/Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

4. You will remain incapable of work from ________________ to ________________

   **Note:** The period entered must NOT exceed 13 weeks

5. Doctor:  
   - Name (printed)  
   - Signature  
   - Date: ________________

**IMPORTANT NOTE:** Any person who for the purpose of obtaining benefit under The National Insurance Act, for himself or for some other person, knowingly makes any false statement or false representations or produces any document, etc. which he knows to be false, shall be liable to a fine not exceeding Two Thousand Five Hundred Dollars ($2,500), or to imprisonment for a period not exceeding twelve (12) months or both.

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**Section D: Claimant’s Declaration (To be completed by the Claimant)**

I declare that:

38. My last day at work was ________________.

39. I am incapable of work and have done no paid work since the date shown at question 38.

40. The information given by me on this form is true and correct to the best of my knowledge and belief.


42. Claimant’s Signature: _____________________________

OR, if unable to sign, 
Agent/Representative’s Name (printed): _____________________________ Signature: _____________________________

Date: ________________

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**For Official Use Only**

**MEDICAL CERTIFICATE OF INCAPACITY FOR WORK**

For Official Use Only

**For Official Use Only**

Form Med 1 (Revised 2012)
**Section B: Claimant Details (To be completed by the Claimant)**

**Note:** This claim form **MUST** be accompanied by a completed Employer's Certificate (Form Med.4), if you are currently employed. This claim **WILL NOT** be processed until the Form Med.4 is received. (The Form Med.4 is not required for Self-Employed Persons.)

6. □ Mr./ □ Mrs./ □ Ms. ________________________ 7. N.I. # ____________________________ 8. Date of Birth ________ dd/mm/yyyy


12. P.O. Box: ____________________________ 13. Email Address: __________________________

**Employment Details**

14. Occupation: __________________________

15. Are you Self-Employed? □ Yes □ No *(If your response is ‘Yes’ then proceed to question 20)*


18. Your Work Employee #: __________________________

19. Employer/Company: __________________________

20. Employer/Self-Employed N.I. #: __________________________

21. Employer/Company Address: __________________________

22. Telephone #1: ________________ 23. Telephone #2: ____________________________

24. P.O. Box: ____________________________ 25. Email Address: __________________________

26. Employment History:

<table>
<thead>
<tr>
<th>Previous Employer/Company Name</th>
<th>Start Date (dd/mm/yyyy)</th>
<th>End Date (dd/mm/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

27. If you were on vacation during the illness period, please state when: ________________ to ________________.

28. If unemployed during the illness period, please state date employment ceased: ________________.

**Section C: Details of Industrial Disease or Accident (To be completed by the Claimant)**

**Note:** This section must be completed if you claim that your incapacity is due to an injury received or a disease contracted while working for an employer/company or due to the nature of your employment. This form **MUST** be accompanied by a completed Employer's Report on Accident at Work (Form B.44). This claim for industrial benefit **WILL NOT** be processed until the Form B.44 is received.

**Industrial Accident**

29. Where did the accident happen? __________________________

30. When did the accident happen? Date: ________________ Time: ________ □ a.m. □ p.m.

31. State briefly how the accident happened? __________________________

**Employed Persons**

33. Did you report the accident to your employer? □ Yes □ No

34. If 'Yes', when? Date: ________________ Time: ________________ □ a.m. □ p.m.

36. If unemployed during the illness period, please state date employment ceased: ________________.

**Industrial Disease**

37. What is the nature of your work which has caused the disease? __________________________

<table>
<thead>
<tr>
<th>Employer/Self-Employed N.I. #</th>
<th>Employer/Company Address:</th>
<th>Date</th>
<th>Time</th>
<th>a.m.</th>
<th>p.m.</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>

38. If 'Yes', when? Date: ________________ Time: ________________ □ a.m. □ p.m.

**Self-Employed Persons**

35. Did you report the accident to the National Insurance Board? □ Yes □ No

36. If 'Yes', when? Date: ________________ Time: ________________ □ a.m. □ p.m.