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

I declare that:

38. My last day at work was _____.
dd/mm/yyyy

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.

41. I claim Benefit/Assistance under the National Insurance Act, 1972.

42. Claimant's Signature: _____

OR, if unable to sign,
Agent/Representative's _____ *Name (printed)* _____ *Signature*

Date: _____ *dd/mm/yyyy*

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.

For Official Use Only

Form Med 1 (Revised 2012)

The National Insurance Act, 1972
Commonwealth of The Bahamas

For Official Use Only

Medical Certificate of Incapacity for Work

Section A:
To be completed by a Registered Medical Practitioner

1. In Confidence to: ☐ Mr. / ☐ Mrs. / ☐ Ms.
_____ _____ _____
Last Name *First Name* *Middle Name(s)*

2. I certify that I examined you on _____ and that in my opinion, you were incapable of working at the time of the examination.
dd/mm/yyyy

3. Diagnosis / Operation:

ICD-9 Code	Description of Diagnosis/Operation

4. You will remain incapable of work from _____ to _____
dd/mm/yyyy *dd/mm/yyyy*
(Note: The period entered must NOT exceed 13 weeks)

5. Doctor: _____ _____
Name (printed) *Signature*

Affix Doctor's Stamp here

Date: _____
dd/mm/yyyy

Note: Claims from Registered Medical Practitioners outside The Bahamas MUST be accompanied by a business card.

Form Med 1

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. _____
Last Name *First Name* *Middle Name(s)*

7. N.I.# _____ 8. Date of Birth _____
dd/mm/yyyy

9. House # & Street: _____

10. Telephone #1: _____ 11. Telephone #2: _____

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)***

16. Department: _____ 17. Supervisor: _____

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:

Previous Employer/Company Name	**Start Date *(dd/mm/yyyy)***	**End Date *(dd/mm/yyyy)***

27. If you were on vacation during the illness period, please state when: _____ to _____ .
dd/mm/yyyy *dd/mm/yyyy*

28. If unemployed during the illness period, please state date employment ceased: _____
dd/mm/yyyy
.

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.
dd/mm/yyyy

31. State briefly how the accident happened? _____

_____

_____

_____

32. What injury did you sustain as a result of the accident? _____

_____

_____

_____

Employed Persons

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

34. If 'Yes', when? Date: _____ Time: _____ ☐ a.m. ☐ p.m.
dd/mm/yyyy

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.
dd/mm/yyyy

Industrial Disease

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

_____

_____

_____