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 1300 302 568 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