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| **To be completed by the insurance company/applicant:** |
| **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Civil reg. no.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Position:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Claim no.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**For the physician (to be completed by the company):**

The answers to questions 9a and 9b should cover a period of *[10]* years prior to the date of the claim, which is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **To be completed by the examining physician** | | | |
| **1** | a) Are you the patient´s general practitioner?  b) If the answer to a) is no:  Do you have another treatment-based association with the patient (speciality, place of treatment)?  c) If the answer to a and b) is no:  I have no treatment-based association with the patient and I have only seen the patient in connection with the completion of this certificate? | **NO YES**  🞎 🞎  **NO YES**  🞎 🞎  **NO YES**  🞎 🞎 | If **YES**, what kind?  ………………………………………………………………………………...  ………………………………………………………………………………... |
| **2** | a) When did you first treat the patient in connection with the current injury or illness?  b) According to the information provided, did the injury or illness occur during working hours? | **NO YES**  🞎 🞎 | Date: ………………………………….……………………………………..  (day/mth/year) |
| **3** | Diagnosis in Danish and Latin: |  | 1. Danish:  1. Latin:  2. Danish:  2. Latin: |
| **4** | Did the injury or illness require hospital admission or outpatient treatment or rehabilitation at the hospital? | **NO YES**  🞎 🞎 | If **YES**, please state:  Where?  During which period? |
| **5** | a) Did the patient state that he/she is on sick leave?  **If the answer to 5 a) is YES, please answer the below questions**  b) Has a notice of sick leave been issued?  c) Does the patient state that he/she has resumed work? | **NO YES**  🞎 🞎  🞎 🞎  🞎 🞎 | If **YES**, please state:  During which periods?  From date :………............. Duration:………………………….  (day/mth/year) (number of days/weeks/mths)  According to the information provided, work has been resumed from date:…………………….  (day/mth/year) |
| **6** | Have there been complications? | **NO YES**  🞎 🞎 | If **YES**, please state:  Which? |
| **7** | a) Has the patient been under medical supervision during the entire course of the illness? | **NO YES**  🞎 🞎  **Don’t know**  🞎 |  |
| **8** | a) Who has previously treated the patient?  b) Is the patient undergoing treatment or rehabilitation?  c) Has the patient been referred for further treatment or rehabilitation?  d) Has treatment or rehabilitation been completed? | **NO YES**  🞎 🞎  🞎 🞎  🞎 🞎 | Name and address:  If **YES**, please state:  With whom (name and address)?  When is it expected to be completed? ………………………………………  (day/mth/year)  With whom (name and address)?  When is it expected to start? ………………………………………  (day/mth/year)  When? |
| **9** | a) To your knowledge, has the patient had any illnesses, complaints or symptoms in the same region within the last *[10]* years?  b) Do you assess, on the existing basis, that illnesses or other conditions within the last *[10]* years have had any influence on the current injury or illness or exacerbated its consequences? | **NO YES**  🞎 🞎  🞎 🞎 | If **YES**, please state:  Which?  Which? |
| **10** | a) Does the patient state that he/she is able to participate in his/her work?  b) Does the patient state that he/she is able to carry out the daily activities (to be completed only for persons who do not work, such as pensioners or children)?  c) Does the patient state that he/she is able to oversee his/her business (to be completed only for self-employed persons or persons in managerial positions)?  d) Which work functions up till now or daily activities does the patient find impossible to carry out? | **NO YES**  🞎 🞎  🞎 🞎  🞎 🞎 | If **YES**, please state:  🞎 Part-time 🞎 Full-time  🞎 Partly 🞎 Fully  🞎 Partly 🞎 Fully |
| **11** | What is the medical reason that the patient is not able to carry out these activities?  **To be completed only if the patient has stated in section 10 that there are activities which cannot be carried out** |  |  |
| **12** | Are you able to assess at this time when the patient will be able to  a) participate in his/her work?  b) fully carry out the daily activities (to be completed only for persons who do not work such as pensioners or children)? | **NO YES**  🞎 🞎  🞎 🞎 | If **YES**, please state:  Approx. from date :…………………………………………………………….  (day/mth/year)  Approx. from date :…………………………………………………………….  (day/mth/year)  Work or daily activities have been resumed from date:  …………………………………………………………………………….  (day/mth/year) |
| **13** | In your assessment, could further treatment or rehabilitation improve the patient’s condition? | **NO YES**  🞎 🞎 | If **YES**, which treatment or rehabilitation (brief description)?  If **NO**, in your assessment, from which date does it seem that there has been no significant progress or improvement in the patient’s condition?  …………………………………………………………………………….  (day/mth/year) |
| **14** | a) In your assessment, will the injury or illness result in permanent disability?  b) Assessment not possible at this time? | **NO YES**  🞎 🞎  🞎 🞎 | If **YES**, please state:  Which? |
| **15** | Date of examination |  | ……………………………………………………………………………..  (day/mth/year) |

Any relevant discharge letters and examination results etc. may be enclosed

The medical information and assessments in this certificate are closely associated with the purpose of the certificate.

Unless otherwise stated, I accept that the company may provide the patient or his/her representative with a copy of the certificate.

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| This certificate has been completed by me in accordance with the existing medical records, my knowledge of the patient, my questions to the patient and my examination of the patient:  ………………….. ………………………………………………  Date Physician’s signature  **Exact address (stamp):** | The certificate is sent in a closed envelope marked "Attest" to: |

Unless otherwise agreed prior to the request to the physician for completion of this certificate, the physician will receive payment upon submission of invoice in accordance with the physician’s terms of business. 04.04.35.04