**FP 300 Initial certificate**

**The certificate forms part of the agreement between Insurance & Pension Denmark and the Danish Medical Association on certificates and health information etc.**

**It has been agreed between the Danish Insurance Association and the Danish Medical Association that the certificate may be completed by any medical doctor**.

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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 5a and 5b should cover a period of *[10]* years prior to the date of the claim, which is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ddmm-yyyy

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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) How does the patient describe the occurrence of the injury or illness?  b) According to the information provided, did the injury or illness occur during working hours?  c) Did the patient state that he/she is on sick leave? | **NO YES**  🞎 🞎  🞎 🞎 | If YES, during which periods?.................................................................... |
| **3** | a) Time of first medical treatment?  b) Who administered the first medical treatment?  (state the name of the physician or hospital) |  | Date: ………………………………….……………………………………..  (day/mth/year)  Name and address: |
| **4** | What are the patient’s current complaints? |  |  |
| **5** | 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? |
| **6** | Diagnosis in Danish and Latin: |  | 1. Danish:  1. Latin:  2. Danish:  2. Latin: |
| **7** | 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**, with whom (name and address)?    If **YES**, with whom (name and address)?    If **YES**, when?.............……………………………………………….  (day/mth/year) |
| **8** | 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 |
| **9** | What is the medical reason that the patient is not able to carry out his/her work or daily activities?  **To be completed only if the patient has stated in section 8 that there are activities which cannot be carried out** |  |  |
| **10** | 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? |
| **11** | 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. 04.04.30.04