

National Insurance Number of Insured Persons	Name of Insured Person (Surname First)	State Whether employment Injury or Sickness	Nature of Injury of Illness	Date	Date(s) of medical attention (including certification)	Particulars of Drugs used and treatment given	Quantity	Charges as per scale			
								Medical examination including certification	Treatment	Drugs and Dressings	Others (please specify)
								\$	\$	\$	\$

I hereby certify that this is a true account of the expenses incurred in the Medical Care and Treatment of employment injury and/or sickness cases for the period stated above.

Date:

Signature of Claimant or Authorised Representative.

Totals _____

Grand Total _____

FOR OFFICIAL USE ONLY

___ I hereby certify that the charges above are fair and reasonable

Date: Medical Adviser:

BENEFITS DIVISION

Number - M.C. No.

1. Checked by:
Date:
2. Authorised for payment subject to check
Amount claimed:
Date: S.E.O:
3. Checked by:
4. Payment Voucher No.....