Financial Insurance Company Limited
Financial Assurance Company Limited
(each part of AXA)
P.O. Box 602, Shannon, Co. Clare

Doctors Statement

Part A : To be completed by Policyholder

Part B & C : To be completed by Doctor

Any fee payable for completion of this form is the claimant's responsibility

Part A : Personal Details *(To be completed by Policyholder)*			
Full Name:			
Address:			
Date of Birth:		**Finance Provider:**	
Claim Number:		**Policy Number:**	

Part B : Information on Patient *(To be completed by Doctor)*				
Please provide details of sickness or accident If accident, please give the cause				
If your patient suffers from more than one sickness or injury, please list them putting the most serious first				
First date your patient consulted you for this condition				
First date you certified the patient unfit for work				
When will the patient be fit to resume work?				
If you do not have an exact date, based on your best judgement within how many weeks or months will the patient be fit to start work again?	Weeks		Months	
If the patient has a back condition, have they had an X-ray?	Yes		No	
If 'Yes', date of X-ray				
Please provide details of X-ray				
If the patient has a psychiatric illness or nervous disorder, including stress and stress related conditions have they been referred to a consultant?	Yes		No	
If 'Yes', date referred				
Consultant's Name				

Is the patient's sickness or injury due to self-inflicted injury, childbirth, pregnancy or miscarriage, alcohol or drug abuse, surgical procedures and medical treatment performed for cosmetic reasons, civil commotion, riot or war, psychological or any mental condition?	Yes		No	

If 'Yes', please provide details		

Please advise us whether your patient has suffered from this or a related condition before?	Yes		No	

If 'Yes', please give details	Dates	Details

If the patient has been admitted to hospital please tell us the following	Date admitted	
	Date Discharged	

Has the patient been referred to or treated by a hospital for this condition?	Yes		No	

Name and address of hospital	
Consultants name	

Was the employee working outside the Republic of Ireland?		
If 'Yes', please give dates	From	To
What country was the employee working in?		

Part C : Doctor's Information *(To be completed by Doctor)*

Doctor's Name:	
Telephone Number:	
Doctor's Address	**Doctor's Stamp**

I certify that this patient is/was under medical attention and in my opinion is/was totally prevented from engaging in his/her normal occupation or profession during the period indicated.

Doctor's Signature:	**Date:**