



From: _____ (Unit/ Dept) To: Employees' Compensation Division
 _____ Labour Department

Medical Report for Employees' Compensation

I. Personnel Particulars:

Name of patient: _____
 Sex: Male Female Age: _____ ID No: _____

II. Details of Consultation

Medical Record Reference No.: _____

The above mentioned patient first attended _____
 at _____(Time) on _____(Date)

Referral: No Yes From: _____
 History of injury at work: No Yes (please specify) _____
 Brief summary of clinical features and history: _____

Condition: likely related to the alleged accident unlikely related to the alleged accident
 others – please specify : _____

III. Past medical and surgical history:

 The above condition was a relapse of past medical and surgical condition: (please specify)
 No Yes _____ Other: _____

IV. Treatment given:

Referral to other units for management: No Yes _____
 Sick leaves given for the above presenting condition (Please specify the dates/period(s):

Expected permanent impairment: No Yes (Please specify) _____ %

Static Physical condition for assessment: No Yes Not yet until _____

Name of doctor: _____ **Post/ Unit:** _____

Signature: _____ **Date:** _____

Endorsed by (Name): _____ **Post:** _____

Signature: _____