TURKS AND CAICOS ISLANDS NATIONAL INSURANCE BOARD

MEDICAL CERTIFICATE FOR INVALIDITY BENEFIT

DOCTOR'S STATEMENT

I hereby certify that I examined ____
(Name of person examined)

on the _______ day of ______________ 20_______ at ____
(Place of examination)

My opinion is that ☐he/ ☐she is likely to be ☐ permanently / ☐ temporary incapable of work as a result of *(Description of condition causing incapacity)*:

____

____

____

and ☐he/ ☐she has been so incapable for a period of _____ consecutive ☐ days ☐ weeks immediately preceding the _______ day of _______________ 20 ________.

Doctor's Name: ____

Doctor's Signature: _____________________________________

Doctor's Address: ______________________________________

Telephone No: ____

Date: ____

PATIENT'S AUTHORIZATION FOR RELEASE

I hereby authorize Dr. ____ to release the relevant information with regard to my medical condition to the National Insurance Board, which must be held in strict confidence. I further grant authority to the National Insurance Board's Medical Board/Medical Referee to obtain any required medical information from other physicians or medical institutions in relation to my claim.

______________________________________ __________________________

Signature of Patient *Date*

FOR OFFICAL USE ONLY: Date Received: ____________________ Claim #: ____________________ Signature: ____________________