

Medical Certificate



Work and Income
Te Hiranga Tangata

A service of the Ministry of Social Development

CLIENT NUMBER



This information will be used to establish the person's entitlement to benefit, and will assist in helping plan their entry into work.

Personal details

Where the person is known by more than one name, please provide the person's last name as it appears on their passport or birth certificate.

Address information is used to assist with identification. It is not used for contact purposes.

Where the person is not enrolled with your practice, you can still complete the form. The case manager may seek further advice before determining support.

We may arrange a second opinion by a designated doctor or request a report from a specialist.

First name(s) Surname or family name

Residential address

Date of birth Day Month Year Gender: Male Female

1. Is the person enrolled with your practice? No Yes

2. Who do you consider best placed to provide this information? Yourself Second opinion

Other

Pregnancy

The Sickness Benefit for pregnancy may start from the beginning of the 27th week of pregnancy or earlier in the case of associated illness or complications. The Sickness Benefit can be payable for up to 13 weeks after the birth of the baby.



Work and Income assesses reassessment of Sickness Benefit at least every 13 weeks. The first reassessment will be after a maximum of 4 weeks.

3. Is the condition pregnancy related? No (Go to Q7) Yes

4. Has the baby been born? Yes Date of delivery Day Month Year (Go to Q20)

OR

Is the person 27 or more weeks pregnant? (Read code ZV22.) Yes Due date Day Month Year (Go to Q20)

OR

Is the person less than 27 weeks pregnant with complications? Yes Please give details

READ Code	Description
1	
2	

5. Unable to work from Day Month Year

6. When should the person's entitlement to benefit next be assessed? Day Month Year (Go to Q20)

Sickness, injury or disability

Please include mental health, pain or associated conditions such as obesity or stress. Please list the condition with the greatest impact on ability to work first. Provisional implies the exact nature of the diagnosis is uncertain at this stage.

People who have ACC cover, or are awaiting a cover decision, may still be entitled to assistance from Work and Income.

7. What are the main clinical conditions affecting the person's ability to work?

READ Code	Description	Is it provisional?	Covered by ACC?
1 E2300	Alcoholism	No	No
2 E2B00	B Depression	No	No
3			
4			

8. If covered by ACC, what is the ACC Number?

Hospitalisation

The benefit may be reduced after a person has been in hospital for 13 weeks or more.

9. Is the person in hospital? No (Go to Q10) Yes

Hospital name Date of admission Day Month Year Expected length of stay (days)

Treatment and interventions

Please indicate if the person is receiving treatment which may interfere with their ability to work.

Questions 10 and 11 relate to planning rather than entitlement. Their completion is therefore optional.

10. Is the person receiving active treatment for any of the conditions listed in Question 7? No Yes Please give details

counselling, pharmacotherapy

11. Are there other interventions which could assist the person into work? No Yes Please give details

? part time work trial

Where an intervention could assist the person into work, Work and Income may consider helping the person access this service.

Impact on ability to work

Please provide a description of how these conditions contribute to the person's inability to work (eg difficulty walking, poor concentration, inability to stand for extended periods).

Work and Income would like to work with all our clients to help them plan for their future, including employment, rehabilitation and social participation.

12. How do the above conditions listed in Question 7 affect the person's ability to work?

Low mood, need for counselling

13. When is the person likely to be capable of:

	Now	< 1 month	1-3 months	3-6 months	> 6 months	Unlikely in foreseeable future
Work planning	<input checked="" type="checkbox"/>					
Training	<input checked="" type="checkbox"/>					
Light/selected duties	<input checked="" type="checkbox"/>					
Part-time work (up to 30 hours per week)	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>			
Full-time work (over 30 hours per week)				<input checked="" type="checkbox"/>		

14. Is the person totally blind (VA < 1/20 with correction)?

No Yes (Go to Q19)

15. Does the person's sickness, injury or disability limit their capacity to seek, undertake or be available for employment for 30 hours or more per week?

No (Go to Q20) Yes

16. Does the person's sickness, injury or disability prevent them from regularly being in open employment for 15 hours or more per week?

No (Go to Q18) Yes

17. Is the person's condition expected to last at least 2 years?
OR
Is the person's life expectancy less than 2 years?

No Yes
No Yes

18. Unable to work from
Day Month Year

19. When should the person's entitlement to benefit next be assessed?

2 years 5 years Never
Day Month Year

Please indicate the date from which the person was first unable to work as a consequence of their medical condition, or the date indicated on the client's re-assessment letter.

Work and Income requires reassessment for Sickness Benefit at least every 13 weeks. The first reassessment will be after a maximum of 4 weeks.

Comments

If the person has a chronic or severe condition, please attach a copy of any recent reports which would help determine appropriate support.

20. Would you like Work and Income to contact you about this person's diagnosis or ability to work?

No Yes

21. Please provide any comments that would assist the case manager determine appropriate support for the person.

Keen to trial work planning

Health practitioner identity

where the person has not consented to the release of the information, Work and Income will be unable to take this information into account when considering an application for benefit.

HPI Number Practitioner type: Doctor Dentist Midwife

I have discussed the information contained in this form with the person (their guardian or their legal representative) and they have agreed with the information being provided to Work and Income.

No Yes

Full name

Practice address

Ph.

Fax

Telephone number ()

Date person examined:
Day Month Year

Date certificate completed:
Day Month Year

Health Practitioner's signature: