SSB .(A3)

MEDICAL REPORT

DISABLITY CLAIM UNDER THE PENSION AND SOCIAL SECURITY BENEFIT SCHEME FOR THE SELF - EMPLOYED PERSONS SRI LANKA SOCIAL SECURITY BOARD

(All particulars have to be inserted by the Medical Officer himself/herself. Cages (a) & (b) also have to be completed in his/her presence.

Medical Report on the life of .....

(Please give the full name of the party who is being examined)

of .....

(Please give the address & the National I.D. No.)

(a) Signature / Thumb impression of the patient on whose life this report is given : .....

(b) Name and Signature of person introducing the patient : .....

1. Is the person to be examined known to you personally or professionally ? .....
2. Are you satisfied about his identity ? .....
3. When were you first consulted by the patient? .....
4. What is the nature of the disabilities / dismemberment experienced by the patient? .....
5. Are you of the opinion that the disabilities / Dismemberment experienced by the patient have arisen as a result of illness or accident? If the disabilities have arisen as a result of illness, what would be the nature of the illness? .....

6. If the claimant has consulted you in connection with the Illness which has given rise to the disabilities / dismemberment, please answer the following questions.

(a) What is the exact nature of the illness for which consultation had been sought by the patient .....

(b) How long had he / she been suffering from this illness? .....

(c) What were the first symptoms of the Illness as reported by the patient? .....

(d) When were the symptoms first observed by the patient (as reported by the patient) .....

(e) How long have you treated the patient for this illness? .....

(Give the names & addresses of the other doctors, if any, who had treated the patient in connection with this illness)

(I) Have you any reason to suppose or to suspect that the illness was caused or aggravated by intemperate habits of the patient? .....

7. If the claimant has consulted you to take Treatment for injuries sustained as a result of an .....

Accident, please answer the following questions.

(a) Are you of the opinion that the Disabilities / dismemberment experienced by the parent have arisen as a result of an accident? .....

(b) What is the nature of the accident (as Reported by the patient) .....

(c) What injuries has the patient sustained as a result of the accident? .....

8. Please state whether the illness / accident Complained of has made the examinee suffer the : .....

(a) Loss of both hands or complete paralysis of both hands .....

(b) Loss of both feet or complete paralysis of both legs .....

(c) Loss of sight in both eyes, (d) Loss of one hand or complete paralysis of one hand .....

and loss of one leg or complete paralysis of one foot, (e) Loss of or complete paralysis of one hand and sight in one eye, (f) Loss of or complete paralysis of one foot and sight in one eye, (g) Loss of sight in one eye, (h) Loss of one hand or complete paralysis of one ~~had~~ hand, (I) Loss on one foot or complete paralysis of one foot or (j) complete paralysis of the body from the neck downwards.

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I. .....

(Please give full name of Medical officer)

being the Medical Officer / Surgeon / Physician / attached to .....

.....

(Name of hospital)

do hereby solemnly declare that the foregoing statements are true and correct to the best of my knowledge and behalf and that the signature / thumb impression in cage (b) above was placed by the person who was examined by me in connection with this Medical Report.

Date at ..... this ..... day of ..... 19.....

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Signature of Doctor

Witness :

Signature ..... Address.....

Name ....

Occupation ....

Address .....

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