

MEDICAL PANEL PROFORMA – Chair of Panel (Worker)

WORKER'S DETAILS

Title (Mr/Ms/Miss/Other) Last name

Given name(s)

Date of birth

Claim Number

MEDICAL QUESTIONS

Does the person have one or more asbestos-related diseases?	<input type="radio"/> YES <input type="radio"/> NO If yes, answer remaining questions
What is the asbestos-related disease or diseases?	<input type="text"/>
Is the contraction of the disease or diseases reasonably attributable to exposure to asbestos at work? Provide explanation.	<input type="text"/>
Does the person have an imminently fatal asbestos-related disease?	<input type="radio"/> YES <input type="radio"/> NO
Does the person have a non-imminently fatal asbestos-related disease?	<input type="radio"/> YES <input type="radio"/> NO
Does the medical panel agree with the whole person impairment assessment (where applicable)? If not, does the medical panel require another whole person impairment assessment to be undertaken?	<input type="text"/>
Does the medical panel agree with the assessment of incapacity for work (where applicable)? If not, does the medical panel require another incapacity assessment to be undertaken?	<input type="text"/>



<p>Has the person recovered from the disease or is the person likely to recover from the disease? Provide explanation.</p>	
<p>Any other relevant medical question?</p>	
<p>Does the medical panel require any other tests or examinations to be performed prior to making a decision? If so, provide details to the Asbestos Compensation Commissioner.</p>	
<p>General comments (if any).</p>	
<p>Reasons for decision or reasons why unable to make a decision.</p>	

MEDICAL PANEL MEMBER DETAILS

Full Name of Chair (Print)

Signature

Date

Full Names of other Medical Panel Members

OFFICE USE ONLY		
Actioned _____	Initials _____	Date _____