MEDICAL PANEL PROFORMA – Panel Member (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?	◯ YES ◯ NO If yes, answer remaining questions
What is the asbestos-related disease or diseases?	
Is the contraction of the disease or diseases reasonably attributable to exposure to asbestos at work? Provide explanation.	
Does the person have an imminently fatal asbestos-related disease?	◯ YES ◯ NO
Does the person have a non-imminently fatal asbestos-related disease?	◯ YES ◯ 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?	
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?	

Has the person recovered from the disease or is the person likely to recover from the disease? Provide explanation.	
Any other relevant medical question?	
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.	
General comments (if any)	
Reasons for decision or reasons why unable to make a decision.	

MEDICAL PANEL MEMBER DETAILS

Full Name of Panel Member (Print)

Signature

Date

OFFICE USE ONLY

Actioned _____ Initials ____ Date _____

Print form