



MEDICAL PANEL PROFORMA – Panel Member

(Member of the family)

FAMILY MEMBER DETAILS

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

Given name(s)

Date of birth

DECEASED WORKER'S DETAILS

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

Given name(s)

Date of birth

Claim Number

MEDICAL QUESTIONS

Did the deceased person have an asbestos-related disease or diseases?	<input type="radio"/> YES <input type="radio"/> NO If yes, answer remaining questions
What was the asbestos-related disease or diseases?	<input type="text"/>
Was the contraction of the disease or diseases reasonably attributable to exposure to asbestos at work? Provide explanation.	<input type="text"/>
Was the asbestos-related disease reasonably likely to have been a significant factor contributing to death?	<input type="text"/>
Did the person have an imminently fatal asbestos-related disease?	<input type="radio"/> YES <input type="radio"/> NO
Any other relevant medical question?	<input type="text"/>



General comments (if any).

Reasons for decision or reasons if unable to make decision.

MEDICAL PANEL MEMBER DETAILS

Full Name of Panel Member (Print)

Signature

Date

OFFICE USE ONLY

Actioned _____ Initials _____ Date _____