9b

ONGOING Medical Certificate for ASBESTOS-RELATED DISEASES Compensation

(may be completed by General Practitioner or Medical Specialist)

Asbestos-Related Diseases (Occupational Exposure) Compensation Act 2011

The Asbestos Compensation Commissioner is the compensation provider for Tasmanian workers that have contracted an asbestos-related disease through their employment in Tasmania.

Please complete all relevant sections of the form. 'As previous' or 'Unchanged' is not considered sufficient information. Where the worker has completed an authority for the release of medical information, please send all relevant test results, scans and reports to the Asbestos Compensation Commissioner, by electronic means where possible (acc@justice.tas.gov.au). This will assist with processing the worker's claim in a timely manner.

WORKER'S DETAILS

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

Given name(s) _____

Date of birth _____

Postal address _____

_____ Postcode _____

Telephone numbers Home _____ Work _____

Mobile _____

Claim number _____

☐ Continuing certificate ☐ Final certificate

INCAPACITY / FITNESS FOR WORK

The patient is currently:

- ☐ fit to continue duties
- ☐ fit to return to duties from _____
- ☐ fit for modified duties, with limitations specified below, from _____ to _____ (max. 12 months on this certificate)
- ☐ already retired from employment

Restrictions

_____

_____

☐ totally unfit for work from _____ to _____ (max. 12 months on this certificate) due to:

(Please specify reasons for incapacity)

_____

_____

_____

_____

☐ The patient has wholly/substantially recovered from the effects of the asbestos-related disease

☐ The patient's incapacity is no longer due wholly/substantially to the asbestos-related disease.

(Please specify grounds for opinion)

_____

_____

_____

_____

Provide details of tests, xrays, scans, results and/or examinations conducted since the INITIAL medical certificate (Form 9a) was completed.

_____

_____

_____

_____

_____

_____

CURRENT MEDICAL TREATMENT SUMMARY (treating medical specialist or doctor to complete)

What type of medical treatment or pharmaceutical treatment is currently required for this disease?

TREATMENT TYPE	BENEFITS OF TREATMENT	DATE OF REVIEW	NUMBER OF SESSIONS

Provide details of any other medical services, nursing services, hospital services, rehabilitation services, ambulance services, constant attendance services, physiotherapy services or psychological services required for the treatment of the disease, include expected duration of treatment where applicable.

Has the patient been referred to another health/medical professional? If yes, provide details.

Has the patient consulted other health/medical professionals? If yes, provide details.

MEDICAL PRACTITIONER DETAILS

Name and address of registered medical practitioner (please print)

Name

Postal address

Postcode

Phone

Fax

Qualifications

Specialty

Occupation

Provider number

Signature

Date

SUBMIT COMPLETED FORM

BY post to:
The Asbestos Compensation Commissioner
PO Box 56
ROSNY PARK TAS 7018

OFFICE USE ONLY

Actioned _____ Initials _____ Date _____

Print form