Medical certificate of incapacity to work for the attention of the life insurers' consulting doctor

ASA | SVV
Schweizerischer Versicherungsverband
Association Suisse d'Assurances
Associazione Svizzera d'Assicurazioni
Swiss Insurance Association

Select insurance...

GLN

Case

Reason ◯ Disease ◯ Accident

Policy no. / Contract No. / Social security number

Start of incapacity to work

1. Patient

Surname

First name

Address

ZIP / City

Sex

Date of birth

Phone

Mail

2. Occupation

Current occupation(s)

Workload hours/day days/week

◯ Employee ◯ Self-employed ◯ Currently not employed

3. Treatment

Outpatient treatment with you since until

Previous outpatient treatment by (name, address, speciality and duration):

Follow-up outpatient treatment by (name, address, speciality and duration):

Inpatient treatment: where?

From when to when? to

In the case of surgery, please provide details:

When and where?

4. Medical history

a) When and how did the disorder first appear?

b) Subjective patient details:

c) Had the patient been treated for this disorder previously? ◯ Yes ◯ No

If so, where?

When?

d) Previous therapies:

e) Are there any pre-existing illnesses and/or consequences of accidents? ◯ Yes ◯ No

If so, please provide details:

Since when?

Who was the consulting doctor/hospital?

Are they affecting the healing process? ◯ Yes ◯ No

If so, to what extent?

5. Objective findings

Examinations, findings of imaging tests, explanations and discharge reports (please provide copies):

Please provide details:

Date

6. Diagnosis

ICD code and differential diagnosis, if applicable:

with an impact on capacity to work

without an impact on capacity to work

Objective restriction on current activities:

7. Other factors

Are there any factors that could have a negative impact on the healing process (e.g. working environment, social factors, commute to/from work, addiction)? ◯ Yes ◯ No

If so, please provide details:

8. Therapy

a) Current treatment and medication (including dosage):

b) Procedure/suggestions (imaging diagnostics, examination by a specialist doctor, treatments, etc.):

c) Prognosis:

9. Incapacity to work

Date of creation	Manageable workload: (% of usual workload):	Manageable presence at work (hours/day):	Incapacity to work as a %:	Incapacity to work from:	Incapacity to work until:

Return to work: planned from: _____ at _____ hours/day

expected in: _____ weeks at _____ hours/day

10. Reintegration

a) Is another reasonable job/activity expected to be considered? ◯ Yes ◯ No

If so, which, and to what extent?

b) Has a new job/activity been started recently? ◯ Yes ◯ No

If so, please provide details:

c) Are there restrictions in the new job/activity? ◯ Yes ◯ No

If so, please provide details:

d) From a medical point of view, is there a restriction on driving a vehicle? ◯ Yes ◯ No

If so, please provide details:

11. Consultations

Date of last consultation

Date of next consultation

12. Other insurers

Are other service providers involved (accident insurers, sickness benefit insurers, invalidity insurance, military insurance, etc.)? ◯ Yes ◯ No

If so, please provide details:

13. Remarks

Doctor's address

Phone

Fax

GLN

ZSR

eMail

Signature

when sent electronic obsolete

Date

Electronic Transfer

«Envoi direct» est désactivé parce que le destinataire ne peut pas être adressé en toute sécurité (HIN-Mail|Medidata)!