

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

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?

[Redacted area]

From when to when? [Redacted] to [Redacted]

In the case of surgery, please provide details: [Redacted]

When and where? [Redacted] [Redacted]

4. Medical history

a) When and how did the disorder first appear?

[Redacted area]

b) Subjective patient details:

[Redacted area]

c) Had the patient been treated for this disorder previously?

Yes No

If so, where?

[Redacted area]

When? [Redacted]

d) Previous therapies:

[Redacted area]

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

Firma _____
when sent electronic obsolete

Date

Electronic Transfer