

MOTOR VEHICLE ACCIDENT FUND MEDICAL FORM

SECTION 1

1.1:	PATIENT'S PART	TICULARS	
	Name		Surname
	Sex	Age	Next of Kin
	Medical Aid		
	Occupation		
	Postal Address		
			(W) E-mail
1.2:	NEXT OF KIN PARTICULARS (as above)		
	Name		Surname
	Sex	Age	Next of Kin
	Medical Aid		
	Occupation		
	Postal Address	711900 A1700-74	
	Telephone	(H)	(W) E-mail

SECTION 2 ACCIDENT DETAILS

Date of	Date of Accident			
Place o	f Accident			
SECTION 3	INJURY DETAILS			
3.1	Injuries sustained as a result of the RTA			
3.2	Treatment administered after the RTA			
SECTION 4	RECOMMENDED FUTURE TREATMENT/SUPPORT			
SECTION 4	RECOMMENDED FOTORE TREATMENT SOLT ON			

SECTION 5: DETAILS OF REPORTING MEDICAL DOCTOR

5.1: Particulars

	Name	Surname
	Name of Hospital/Clinic	
	Address	
	Telephone	Fax
	Email	
	Signature	Date
	Official Stamp	
5.2:	DETAILS OF CLAIM	
	Invoice #	
	Amount Claimed	

N:B ATTACH THE ORIGINAL INVOICE

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