MOTOR VEHICLE ACCIDENT FUND

MEDICAL FORM

SECTION 1

1.1: PATIENT'S PARTICULARS

Name____________________ Surname____________________

Sex__________ Age________ Next of Kin____________________

Medical Aid____

Occupation____

Postal Address____

Physical Address____

Telephone__________(H)__________(W) E-mail__________

1.2: NEXT OF KIN PARTICULARS (as above)

Name____________________ Surname____________________

Sex__________ Age________ Next of Kin____________________

Medical Aid____

Occupation____

Postal Address____

Physical Address____

Telephone__________(H)__________(W) E-mail__________

Impression House 3163808

SECTION 2 ACCIDENT DETAILS

Date of Accident ____

Place of Accident ____

SECTION 3 INJURY DETAILS

3.1 Injuries sustained as a result of the RTA

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3.2 Treatment administered after the RTA

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SECTION 4 RECOMMENDED FUTURE TREATMENT/SUPPORT

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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