Medical Certificate

For CTP Insurance Claims
to be completed by a Medical Practitioner

For information on the Qld Compulsory Third Party Scheme phone the CTP Enquiry line on 1300 302 568

Injured Person's information

Injured person's surname/family name

Given names

Date of birth / / DD/MM/YYYY

Medical information

Date of accident / / DD/MM/YYYY

Date of initial examination / / DD/MM/YYYY

Are the injuries/conditions consistent with the circumstances of the motor accident described to you? ☐ Yes ☐ No

Medical diagnosis or description of injury

Clinical findings (symptoms, results of any investigations, and details of treatment/rehabilitation to date)

Patient treated at hospital? ☐ Yes ☐ No

If admitted to hospital, was it longer than 24 hours? ☐ Yes ☐ No

Did patient require an ambulance? ☐ Yes ☐ No

Name of hospital

Proposed treatment plan

Treatment likely to be required: ☐ Nil ☐ Short term (<6 weeks) ☐ Medium term (6-12 weeks) ☐ Long term (>12 weeks)

Details of treatment plan (including recommendations and advice to patient)

Referred to:	Type	Name of person	Phone number or contact details
☐ Specialist			
☐ Therapy			
☐ Other			

Describe the patient's fitness for work

☐ Fit to resume normal duties on	/ /
☐ Fit for alternative duties on	/ /
☐ Unfit for work from	/ / to / /

DD/MM/YYYY DD/MM/YYYY

Date of next medical review / / DD/MM/YYYY

Medical Practitioner's information

Name (please print)

Provider number

Practice name and address/hospital name

Telephone number ( )

Professional qualification

I declare that I am a registered medical practitioner and to the best of my knowledge the information provided here is true and correct.

Signature

Date / / DD/MM/YYYY

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