



FEDERAL REPUBLIC OF NIGERIA

NIGERIA SOCIAL INSURANCE TRUST FUND (NSITF)

(Employees' Compensation Act, 2010)

Claim No.

Medical Report for Accident/Occupational Disease

(Section 27(1) & (2) of the Act)

Indicate whether Accident: or Occupational Disease:
 First Report Progress Report Final Report N.B. Attach details, where necessary

1. Full Names of Employee: Surname: First Name:
 Middle Name:

2. Name of Employer:
 3. Employer Reg. No.:

4. Date of Accident/Onset of Occupational Disease: (dd/mm/yyyy)

5. Date of first consultation: (dd/mm/yyyy)

6. Describe how the accident happen or indicate the causative substance of Occupation Disease.

7. Full clinical description of injury(ies) or diagnosis/nature of disease _____

8. Describe briefly any pre-existing defect/disease: _____

9. State the positive aspects from the anamnesis and/or clinical examination supporting the diagnosis (reports of all special investigations must be submitted) _____

10 Surgical procedures: Date (dd/mm/yyyy) ____/____/____ By whom: _____

Brief description:- _____

11 Anesthetic: General/Local: - _____ Duration: _____

12 (a) Consultation: Yes No With whom: - _____

Date: (dd/mm/yyyy) ____/____/____ (b) Was the employee referred for physiotherapy? Yes No

Name of Physiotherapist: - _____

13 (a) Is the employee unfit for work? Yes No (b) Possible date fit for light duty:- ____/____/____

Possible date fit for normal duty: - ____/____/____

14 Account in respect of consultant and/or procedure(s)

Hospital/Consultant's Account No: _____ Hospital Retainer's ID. No.: _____

Description of Service	Place and date of Treatment or Visits	Item of Tariff	N	K

I certify that I have by medical examination of the employee satisfied my self of the above-mentioned facts.

Medical Practitioner Surname:

First Name: Middle Name:

Practice No.: Date: (dd/mm/yyyy) ____ / ____ / ____

RegisteredAddress: _____
