

HOW LONG HAVE YOU BEEN TREATING THE PATIENT?

Y	Y	-	M	M
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MEDICAL HISTORY (Past Examinations/Diagnosis/Severity/Prognosis/Functional Status)

PRESENT OCCUPATIONAL STATUS

TREATMENT PLAN & MEDICATION REQUIRED

HABITAT STATUS

ALCOHOL

Type	Quantity
Daily	Weekly

IF YES, INDICATE USAGE PATTERN

SMOKER

Y	N
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IF YES, INDICATE USAGE PATTERN

STARTED	D	D	M	M	Y	Y
ENDED	D	D	M	M	Y	Y

HAS THE PATIENT BEEN EDUCATED ON THEIR SMOKING HABITS?

Y	N
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BODY MASS INDEX (BMI)

WEIGHT Kg

HEIGHT m

ARE THERE ANY DIETARY OR LIFESTYLE ADJUSTMENTS NEEDED?

HAS THERE EVER BEEN A PROBLEM WITH NON- OR POOR COMPLIANCE RELATING TO MEDICAL ADVICE OR TREATMENT GIVEN TO THIS PATIENT?

DOCTOR'S ASSESSMENT OF WHY THIS CASE SHOULD BE REGARDED AS AN EXCEPTIONAL MEDICAL CIRCUMSTANCE THAT COULD NOT BE MANAGED WITHIN THE ALLOCATED BENEFITS

DOCTOR NAME

PRACTICE NUMBER

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Date:

D	D	M	M	Y	Y
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Signature

SECTION C

FINANCIAL REPORT (COMPLETION IS COMPULSORY) (to be completed by member)

MONTHLY EXPENDITURE

	MEMBER	SPOUSE
BOND/RENT	R	R
MUNICIPAL RATES & TAXES	R	R
ELECTRICITY & WATER	R	R
TELEPHONE (TOTALS OF ALL TYPES)	R	R
HIRE PURCHASE PAYMENTS – SPECIFY	R	R
a)	R	R
b)	R	R
c)	R	R
INSURANCE PREMIUMS	R	R
TRANSPORT	R	R
DOMESTIC & GARDEN HELP	R	R
GROCERIES	R	R
CLOTHING	R	R
OTHER	R	R
TOTAL EXPENDITURE	R	R

	MEMBER	SPOUSE	TOTAL
GROSS SALARY			
GROSS PENSION			
OTHER INCOME			
TOTAL INCOME			
TOTAL DEDUCTIONS			
TOTAL NET INCOME			
NET CASH SURPLUS/DEFICIT			

STATEMENT OF ASSETS

ASSETS	VALUE	LIABILITIES	VALUE
RESIDENTIAL PROPERTY OWNED	R	MORTGAGE BOND	R
OTHER PROPERTIES OWNED	R	MORTGAGE BOND	R
OWNED	R	MORTGAGE BOND	R
OWNED	R	MORTGAGE BOND	R
SHARES & INVESTMENTS	R	BANK/OVERDRAFT	
DEBTORS & LOANS	R		
OTHER SIGNIFICANT ASSETS	R		
TOTAL	R	TOTAL	R

I, _____ the undersigned hereby certify that the information provided and stated above in this document is true and correct.

Signature

Date:

D	D	M	M	Y	Y
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SECTION D

EMPLOYER / PENSION FUND INFORMATION

(to be completed by employer or pension fund - only if request is based on financial hardship)

SHOULD THE PENSION FUND ADMINISTRATOR NOT BE AVAILABLE, A COPY OF THE APPLICANT'S LATEST PENSION SLIP AND/OR TAX RETURN MUST BE PROVIDED.

NAME OF COMPANY

WE CONFIRM THAT IS/WAS AN EMPLOYEE OF OUR COMPANY, AND RECEIVES/

RECEIVED A GROSS SALARY/PENSION OF R PER MONTH.

LENGTH OF SERVICE WITH THE COMPANY Y Y - M M

RECOMMENDATION BY EMPLOYER/PENSION FUND

CONTACT PERSON	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
DESIGNATION	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
TEL (W)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
CELL	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
EMAIL	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Signature

COMPANY STAMP

OFFICE USE ONLY FINANCIAL REPORT

PREVIOUS MEDICAL SCHEME			
OPTION			
DOES THE MEMBER OWE ANY MONEYS TO THE SCHEME? YES NO IF YES, SPECIFY AMOUNT :	YES	NO	If YES, specify amount : <input type="text"/>
PREVIOUS EX GRATIA GRANTED	YES	NO	