Medical certificate of incapacity to work for the attention of the life insurers' consulting doctor

ASA | SVV
Schweizerischer Versicherungsverband
Association Suisse d'Assurances
Associazione Svizzera d'Assicurazioni
Swiss Insurance Association

Select insurance...

GLN

Case

Reason ◯ Disease ◯ Accident

Policy no. / Contract No. / Social security number

Start of incapacity to work

1. Patient

Surname

First name

Address

ZIP / City

Sex

Date of birth

Phone

Mail

2. Occupation

Current occupation(s)

Workload hours/day days/week

◯ Employee ◯ Self-employed ◯ Currently not employed

3. Treatment

Outpatient treatment with you since until

Previous outpatient treatment by (name, address, speciality and duration):

Follow-up outpatient treatment by (name, address, speciality and duration):

Inpatient treatment: where?

From when to when? to

In the case of surgery, please provide details:

When and where?

4. Medical history

a) When and how did the disorder first appear?

b) Subjective patient details:

c) Had the patient been treated for this disorder previously? ◯ Yes ◯ No

If so, where?

When?

d) Previous therapies:

e) Are there any pre-existing illnesses and/or consequences of accidents? ◯ Yes ◯ No

If so, please provide details:

Since when?

Who was the consulting doctor/hospital?

Are they affecting the healing process? ◯ Yes ◯ No

If so, to what extent?

5. Objective findings

Examinations, findings of imaging tests, explanations and discharge reports (please provide copies):

Please provide details:

Date

6. Diagnosis

ICD code and differential diagnosis, if applicable:

with an impact on capacity to work

without an impact on capacity to work

Objective restriction on current activities:

7. Other factors

Are there any factors that could have a negative impact on the healing process (e.g. working environment, social factors, commute to/from work, addiction)? ◯ Yes ◯ No

If so, please provide details:

8. Therapy

a) Current treatment and medication (including dosage):

b) Procedure/suggestions (imaging diagnostics, examination by a specialist doctor, treatments, etc.):

c) Prognosis:

9. Incapacity to work

Date of creation	Manageable workload: (% of usual workload):	Manageable presence at work (hours/day):	Incapacity to work as a %:	Incapacity to work from:	Incapacity to work until:

Return to work: planned from: at hours/day

expected in: weeks at hours/day

10. Reintegration

a) Is another reasonable job/activity expected to be considered? ◯ Yes ◯ No

If so, which, and to what extent?

b) Has a new job/activity been started recently? ◯ Yes ◯ No

If so, please provide details:

c) Are there restrictions in the new job/activity? ◯ Yes ◯ No

If so, please provide details:

d) From a medical point of view, is there a restriction on driving a vehicle? ◯ Yes ◯ No

If so, please provide details:

11. Consultations

Date of last consultation

Date of next consultation

12. Other insurers

Are other service providers involved (accident insurers, sickness benefit insurers, invalidity insurance, military insurance, etc.)? ◯ Yes ◯ No

If so, please provide details:

13. Remarks

Doctor's address

Phone

Fax

GLN

ZSR

eMail

Firma

when sent electronic obsolete

Date

Electronic Transfer

«Invio diretto» è disattivato perché il destinatario non può essere indirizzato in modo sicuro (HIN-Mail|Medidata)!