[Logo insurance company]

Annex 5

To be completed by your doctor

MEDICAL CERTIFICATE

The undersigned medical doctor,

Name: ....

Address: ....

hereby certifies that:

First name, last name: ....

Address: ....

was the victim of an accident on (date) ..../........./......... at (place)

....

Consequences of the accident

- First consultation in connection with the accident (date and time): ....
- Description of the nature of injuries:

  ....

  ....

  ....
- Was the victim admitted to hospital? □ Yes □ No

  If yes, from ..../........./......... to ..../........./......... inclusive
- The victim □ is still undergoing treatment

  □ has been recovered since ..../........./.........
- Is the victim temporarily unable to perform day-to-day tasks (work, study, household chores, etc.)? □ Yes □ No

  If yes, periods and levels of incapacitation:

  from ..../........./......... to ..../........./......... inclusive at .... %

  from ..../........./......... to ..../........./......... inclusive at......... %

  from ..../........./......... to ..../........./......... inclusive at .... %

  from ..../........./......... to ..../........./......... inclusive at .... %
- Is the victim expected to make a full recovery? □ Yes □ No

  If yes, on (date) ..../........./.........
- Is the victim expected to remain permanently disabled/incapacitated? □ Yes □ No
- If no, what is the expected evolution of the permanent incapacitation? %
- Additional information: ....

  ....

  ....

Done at: ....

On: ..../........./..........

Signature and stamp of doctor

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