



4 In your opinion as a medical practitioner, the patient was/is unfit for work from

DD / MM / YYYY to DD / MM / YYYY

Provide additional information, if relevant, about the patients ability to work.

Form with 6 horizontal lines for text entry.

5 Can the patient currently perform any other work?

- No [checkbox] Go to next question.
Yes [checkbox] Please explain what other type of work is possible and the approximate number of hours they would be able to work.

Form with 6 horizontal lines for text entry.

6 Are there likely to be long-term limitations on the patient's ability to work full time in future?

- No [checkbox] Go to Question 8
Yes [checkbox] Please provide details of those limitations

(e.g. patient cannot work more than 3 hours a day because they are unable to sit for long periods of time)

Form with 6 horizontal lines for text entry.

7 How long are these limitations likely to last?

- [checkbox] less than 3 months
[checkbox] 3-6 months
[checkbox] 7 - 12 months
[checkbox] 1-2 years
[checkbox] more than 2 years

Provide additional information if relevant.

Form with 6 horizontal lines for text entry.

8 Statement

I declare that:

- I have examined the above named patient.

I certify that:

- the patient is unfit for work for the reasons listed above.
the patient was/is unfit for work for the period stated at question 4.

Your name

Text input field for name.

Practice address

Form with 3 horizontal lines for address, including a Postcode label.

Practice phone number

Text input field for phone number with parentheses.

Your signature

Form with a signature icon and a large text area.

Date

DD / MM / YYYY