

B TO BE COMPLETED BY CLAIMANT

- 1. Full name of claimant
- 2a. Address..... Tel No:
- 2b. Occupation
- 2c. Name and address of employer
- 3a. Nature of injury sustained
- 3b. Probably date of return to work
- 4. Name and address of doctor or hospital treating injury
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- 5a. Date of commencement of incapacity
- 5b. Date first attended by medical authority
- 6. Do you play for another club? YES / NO
- 6a. Name of club Name of League:
- 6b. Name and address of Club Secretary
- Tel No:
- 7. I certify that I am completely incapacitated from following my occupational by reason of this injury.

Signed: (Claimant) Date

C MEDICAL CERTIFICATE (SEE NOTE AT HEADING)

(THIS FORM AND OTHER CERTIFICATION OT BE PROVIDED AT CLAIMANTS EXPENSE)

I certify that A) Mr
is suffering from
caused to the best of my knowledge by
which is the sole cause of his present incapacity.

I declare that to the best of my knowledge at the time of the present injury the patient was not suffering from any previous physical condition or weakness likely to have been the cause of contributed to the present injury.

Date of first attendance to me by hospital casualty

Anticipated duration of patients total incapacity from work weeks.

Signed (Qualifications)