APPENDIX 2: PERMANENT PARTIAL DISABILITY (PPD) / TOTAL PERMANENT DISABILITY (TPD) MEDICAL REPORT – "PART A"

MEDICAL CERTIFICATION FOR PERMANENT PARTIAL DISABILITY (PPD) / TOTAL PERMANENT DISABILITY (TPD)	
THE FOLLOWING INFORMATION MUST BE COMPLETED BY ATTENDING PHYSICIAN Please use separate sheet of paper if additional space is required	
A. DIAGNOSIS	
1. Details of the exact diagnosis.	
2. Date of onset of symptoms and date of any recurrences.	
3. Date of patient's first consultation with you for this condition.	
4. When was the patient informed of this diagnosis?	
5. To your knowledge, please indicate the date from which the patient first become aware of the symptoms or conditions?	
6. Was the patient referred to you from another clinic/hospital? If YES, please state the referring clinic/hospital's address and telephone number.	
7. Has the patient suffered any previous episodes of this condition or any condition leading to it or relating to it? If YES, please provide the details.	Date Symptoms Diagnosis Treatment
8. Has the patient undergone any surgical procedures for this any condition leading to it or relating to it? If YES, please provide the details.	Date Hospital Diagnosis Surgical Procedures
B. DISABILITIES	
1. What is the extent and severity of the patient's condition (e.g. is he/she able to commute by himself/herself? Is he/she able to concentrate on and complete the task by himself/herself, if so for how long?)	
2. Is the patient's condition improving, stable or deteriorating?	
3. Is the patient's condition permanent? If YES, please provide the estimated percentage of permanent disability against the 100% ability of its original function.	
4. What is the extent of the patient's expected recovery from this condition?	
5. When would the recovery be expected?	
6. To what extent would the patient's current condition affect his/her ability to perfom his/her usual occupation?	
7. To what extent would the patient's ability to perform his/her usual occupation be affected after his/her expected recovery?	
8. To what extent would the patient's current condition affected his/her ability to perform any other occupation?	
9. To what extent would the patient's ability to perform any other occupation be affected after his/her exected recovery?	
10. Is the patient capable of practising current occupation on a full-time or part-time basis?	
11. Is the patient capable of practising other occupation? If yes, please describe type of work?	

APPENDIX 2: PERMANENT PARTIAL DISABILITY (PPD) / TOTAL PERMANENT DISABILITY (TPD) MEDICAL REPORT – "PART B"

MEDICAL CERTIFICATION FOR PERMANENT PARTIAL DISABILITY (PPD) / TOTAL PERMANENT DISABILITY (TPD)

THE FOLLOWING INFORMATION MUST BE COMPLETED BY ATTENDING PHYSICIAN
Please Use Separate Sheet Of Paper If Additional Space Is Required

C. ACTIVITIES OF DAILY LIVING : Please comment on whether the patient is able to perform the following activities of daily living

Washing, bathing Ability to wash or bath or shower or by other means to maintain personal cleanliness.	☐ Yes ☐ No	Comments
Dressing Ability to dress and undress and to put on and take off any medical appliances usually worn.	☐ Yes ☐ No	Comments
Toileting Ability to do all of the following: to get to and from lavatory, to get on and off the lavatory, to maintain adequate level of personal hygiene.	☐ Yes ☐ No	Comments
Continence Ability to voluntarily control bowel and bladder function with or without the use of catheters, incontinence or other artificial aids.	☐ Yes ☐ No	Comments
Feeding Ability to take any form of nourishment once it had been prepared and made available.	☐ Yes ☐ No	Comments
Mobility Ability to move in and out of a chair or bed.	☐ Yes ☐ No	Comments
Restriction in movement or lifestyle? If so, please give details.	☐ Yes ☐ No	Comments

D. ACTIVITIES OF DAILY LIVING

Temporary Partial Disablement I hereby certify that the patient has suffered temporary partial disablement due to the above condition and has been able to perform only light duties of his usual duties or jobs during the following periods:	From: D D / M M / Y Y Y Y To: D D / M M / Y Y Y Y
Temporary Total Disablement I hereby certify that the patient has suffered temporary total disablement due to the above condition and has not been able to perform any of his usual duties or jobs during the following periods:	From: D D / M M / Y Y Y Y To: D D / M M / Y Y Y Y
Permanent Partial Disablement I hereby certify that the patient has suffered permanent partial disablement due to the above condition and the details are as follows:	Percentage of Disability : ☐☐ % Please state which limbs and details of its disablement
Total Permanent Disablement I hereby certify that the patient has suffered permanent partial disablement due to the above condition and the details are as follows:	Please state which limbs and details of its disablement
Please provide additional information, if any:	

E. DECLARATION BY THE ATTENDING PHYSICIAN

To the best of my knowledge, I hereby declare that all the information given above are true and accurate.

Name of Patient : _____

NRIC/BC/Passport No. : _____ MRN : _____

Signature of Attending Physician : _____ Professional Qualifications: _____

Name: _____

Official Seal: _____ Date: _____

F. MEDICAL INFORMATION AUTHORISATION

I / we hereby authorise any hospital, surgeons, medical practitioners or clinics or other persons who have attended or examined me or my child for any reasons to disclose any and all information with respect to any illnesses or injuries and to provide copies of all medical reports, including earlier medical history. A copy of this authorisation shall be considered as effective and valid as original.

Bahawasanya dengan ini, adalah saya / kami membenarkan mana – mana hospital, pakar bedah, pegawai perubatan atau klinik atau orang perseorangan lain yang pernah merawat atau memeriksa saya atau anak saya atas apa jua sebab, untuk memberikan sebarang dan semua maklumat berkaitan penyakit atau kecederaan dan menyediakan salinan laporan perubatan termasuk sejarah perubatan terdahulu. Salinan kebenaran ini hendaklah juga dianggap sebagai sah sepertimana salinan asalnya.

Date (DD/MM/YYYY) /
Tarikh (HH/BB/TTTT)

_____
Signature of person with critical illness / terminal illness or his / her guardian
Tandatangan pihak yang mengalami penyakit kritikal / penyakit membawa maut atau penjaga