guardian INSURANCE™

Guardian Income Protection Insurance Claim Form

- To assist us in ensuring you receive a prompt assessment, please complete all the required sections of this booklet. If you need assistance please call us on **1300 308 578**. Please note however, that a claim cannot be assessed until we receive all original documents.
- Please note that the information required to be completed in this document is in relation to the Life Insured, unless otherwise stated.
- To ensure that the claim may be assessed fully, and to avoid any delays to this process, please ensure that all the relevant questions in this document are fully addressed and answered. Responses such as "refer to doctor", "see above", etc. are not acceptable. Failure to address and answer all questions in this document may result in the refusal or delay of benefit payments.
- If for any reason there is not enough room on this document to provide the details being requested please attach a separate piece of paper and provide the details on this, and also make reference to which question on this document you are addressing. Please ensure that you sign and date the piece of paper.
- Please note that it is the Policyowner's or Life Insured's responsibility for the payment of all fees associated in the completion of the Specialist Medical Report or Confidential Report.
- If the Policyowner nominated a third party beneficiary for the Final Expenses Insurance benefit (if applicable), in accordance with the Insurance Contracts Act, the proceeds will be paid to the third party. If no nomination has been made, the proceeds will be paid to the Estate.

Filling in this form:

- Use a black or blue pen
- Mark boxes like this ☐ with ✓ or ✗

There are 2 parts to the claim form:

- **Part A** is to be completed by Life Insured.
- **Part B** is to be completed by the registered Medical Practitioner treating the Life Insured.

Distributed by
Greenstone Financial Services Pty Ltd
trading as Guardian Insurance
ABN 53 128 692 884, AFSL 343079.

Issued by
Hannover Life Re of Australasia Ltd
ABN 37 062 395 484
Tower 1, Level 33, 100 Barangaroo Avenue,
Sydney NSW 2000
Phone: (02) 9251 6911
Email: hlra@hlra.com.au

H4771 G IP Claim HLRA 01/20

Please return this form to Guardian Insurance, Reply Paid 6728, Baulkham Hills NSW 2153

PART A:
Income Protection Insurance Claim Form

guardian INSURANCE™

Privacy Collection Notice

Greenstone Financial Services Pty Ltd ("GFS", "we", "us" or "our") collects and handles personal information about you on behalf of Hannover Life Re of Australasia Ltd ("HLRA") in compliance with the Privacy Act 1988 (Cth). All information collected throughout the claims process by GFS or HLRA will be shared with both companies.

Collection and use

We collect personal information such as identification information and policy details and sensitive information such as health details. Generally, we collect this information so that we can provide our products and services to you and manage, administer, develop and improve our business, including to assess and process your application for insurance, and assess any claims made by you or on your behalf. We generally collect this information directly from you but may collect it from a third party such as our related bodies corporate, authorised administrators, professional advisers or from publicly available information. If you do not provide us with all or part of the personal information we require, we may be unable to provide such services to you.

Disclosure

The information you provide us will be collected by us and may be disclosed to third parties that help us deliver and improve our products and services (including other insurance/reinsurance companies, legal practitioners, Medical Practitioners, health service providers, hospitals, legal tribunals and courts, dispute resolution bodies, investigators/investigation organisations, third parties authorised by you, any current or former employer, our parent company and other related bodies corporate, professional advisers such as accountants or lawyers or other consultants, service providers that assist us in carrying out our business activities, trustees of superannuation funds, administrators of superannuation funds, an organisation appointed by the trustees of a superannuation fund to receive or give information, interpreters and regulatory bodies, government agencies, law enforcement agencies or, as required, other persons authorised or permitted by law) or as required by law.

Overseas disclosure

We or HLRA may disclose your personal information to parties located in other countries, including to our related bodies corporate. The countries in which these recipients may be located will vary from time to time, but may include Germany, Canada, Japan, New Zealand, Hong Kong, United Kingdom, United States of America, India, China, Korea, Malaysia, South Africa, Bermuda, Ireland, Sweden and France.

Access correction and complaints

You can read more about how we collect, use and disclose your personal information in our Privacy Policy, including how to complain about a breach of the Privacy Principles, which is available on our website or you can request a copy by contacting us.

HLRA's Privacy Policy is also available at hannover-re.com/1094181/australia_lh_privacy (or, by contacting HLRA using the details set out in this form or emailing privacyofficer@hlra.com.au). It outlines HLRA's personal information handling practices, including details on how you can seek access or correction of the personal information that HLRA hold about you, how to complain if you believe HLRA has breached the Australian privacy laws and HLRA's complaint handling processes.

If you wish to gain access to your information (including correcting or updating it), have a complaint about a breach of your privacy or have any other query relating to privacy, please call **1300 709 431** Monday to Friday, 8am – 8pm AEST.

Section A – Policy Information

Policyowner _____ Policy number _____

Section B – Life Insured's Details

Title _____ First name _____ Surname _____

Date of birth DD / MM / YYYY Gender: Male ☐ Female ☐

Residential address _____

Postal address _____

Phone (home) _____ (work) _____ (mobile) _____

Email _____

Section C – Income Protection Insurance Claim

1. Injury details

a. Where did this injury occur? (place/address)?

b. What date and time did this injury occur? DD / MM / YYYY TIME

c. Please provide a detailed description of how you were injured?

d. Were there any witnesses to your injury, and if so, what are their names and contact details?

e. Did ambulance, first aid officer or police attend following your injury? No ☐ Yes ☐ ▶ Who attended and what did they do?

f. Was the injury or accident related to your employment? No ☐ Yes ☐ ▶ How is it related to your employment?

2. Illness details

a. Please describe in detail the illness suffered:

3. General injury or illness details

a. What date did the symptoms of your injury or illness first occur? DD / MM / YYYY

b. Please provide a full description of the symptoms resulting from your injury or illness in the area provided below. If there are more than 5 symptoms please attach a separate sheet with all details in the same format.

Symptom	How often does this symptom occur?	How does this symptom prevent you from working?
1		
2		
3		
4		
5		

c. Have you had this, or a similar injury or illness before?

No ☐ Yes ☐ ▶ Please provide the date and circumstances. DD / MM / YYYY

4. Details of hospitalisation

a. Please provide names and addresses of all the hospitals you were admitted to:

Name of hospital and/or name of doctor consulted in hospital	Admission date	Discharge date
	DD / MM / YYYY	DD / MM / YYYY
	DD / MM / YYYY	DD / MM / YYYY
	DD / MM / YYYY	DD / MM / YYYY
	DD / MM / YYYY	DD / MM / YYYY
	DD / MM / YYYY	DD / MM / YYYY

b. If you had an operation, please detail what type of operation it was?

c. What date did you have the operation? DD / MM / YYYY

d. What is the name, address and telephone number of the doctor who performed the operation?

Name	Address	Telephone

5. Details of treatment

a. In date of chronology, please provide full details of all the medical treatment you have received since the onset of your symptoms. If your treatment has included medication, please provide details of the type of medication and dosage.

Medication and treatment	Dosage or medication and frequency of treatment	Doctor prescribing medication and administering treatment (name and address required)	Effect of medication and treatment on symptoms

b. What is the name, address and telephone number of your usual doctor?

Name	Address	Telephone

c. For how long have you been attending your usual doctor?

6. Details of work in your occupation immediately prior to your disability

a. What is your job title/occupation?

b. Please tick the amount of manual labour your occupation involves:

☐ Nil ☐ 1-20% ☐ 21-40% ☐ 41-60% ☐ 61-80% ☐ 81% or more

c. Please list all work duties performed in your occupation immediately prior to your disability. *(Please note that the percentage of working time must equal a total of 100%).*

Duty	Percentage of Working Time
	%
	%
	%
	%
	%

d. How long have you been undertaking all the above listed work duties prior to your disability?

e. How many hours per week did you spend performing all the above listed duties immediately prior to your disability?

f. Were the duties you were attending prior to your disability any different to your normal work duties? If so, please describe how were they different:

g. Please list all your work duties you are **unable** to perform due to your illness or injury:

h. Please list all your work duties that you are still **able** to perform:

i. Have you stopped work completely?

No ☐ Yes ☐ ▶ What date and time did you stop all work completely? DD / MM / YYYY TIME

j. Since completely stopping work have you undertaken any work, regardless whether it is paid work or not?

No ☐ Yes ☐ ▶ Please provide full details of the work that you have undertaken including all the dates, work duties, the number of hours per day worked, and the place of work.

Dates worked	Work duties	No of hours worked per day	Place of work
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			

k. If you have not returned to work yet, when do you expect to be able to return to work? Full Time: DD / MM / YYYY Part Time: DD / MM / YYYY

7. Income

a. What was your average weekly income before your disability commenced? $ Per week
(Please provide us with a copy of your payslips immediately prior to your disability)

b. If you have returned to work in a reduced capacity, what is your weekly income? $ Per week
(Please provide a copy of your payslips)

c. Do you have any other source of income?

No ☐ Yes ☐ ▶ Please provide details of the source of income, frequency and gross amount.

Please ensure that all questions have been answered before you proceed further.

8. Disclosure of information – doctor's authority

Releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, **Hannover Life Re of Australasia Ltd,** collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Even if we collect information from health providers (such as your General Practitioner), before the insurance starts you must still tell us every matter (including about your health) that is relevant to our decision about whether to offer you insurance, and if so, on what terms. This is your Duty of Disclosure under the Insurance Contracts Act 1984 (Cth).

Please read each Authority carefully and the explanatory notes below.

Doctor's Authority 1 – Release of information, excluding consultation notes

Explanatory notes: Through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

Doctor's Authority 2 – Release of full record

Explanatory notes: Through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Doctor's Authority 1 – Release of information, excluding consultation notes

Release any of my health information except the consultation notes held by my General Practitioner/Practice

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to Hannover Life Re of Australasia Ltd, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form Hannover Life Re of Australasia Ltd asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- Hannover Life Re of Australasia Ltd can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while Hannover Life Re of Australasia Ltd is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim

Life Insured's name

SIGN HERE ✗

Life Insured's signature

DD / MM / YYYY

Date

Doctor's Authority 2 – Release of full record

Release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to Hannover Life Re of Australasia Ltd, or to third parties they engage, only if Hannover Life Re of Australasia Ltd. has asked them for a report on my health and either:

- The General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- Hannover Life Re of Australasia Ltd can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while Hannover Life Re of Australasia Ltd is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Life Insured's name

SIGN HERE ✗ Life Insured's signature

DD / MM / YYYY Date

Section D – Policy Discharge

(Please note this section of the form will only be used if HLRA accepts liability for the claim)

☐ I/We hereby request payment of the benefit payable for the Income Protection Insurance (details on page 2 of this document), in full satisfaction for all claims whatsoever under the Policy for the above Life Insured

Life Insured's name

and do hereby discharge HLRA from all liability there under other than for payment of the benefit.

Section E – Declaration & Consent

I have read and carefully considered the questions in this document and that all the responses are true and correct in relation to me.

I ACKNOWLEDGE that this Declaration is part of a claim for an Income Protection benefit and that the making of a false statement may invalidate my claim, and that if I fail to provide all or part of the information **Hannover Life Re of Australasia Ltd. ("HLRA")** requires to assess this claim, it will not be assessed and processed, and that I am the Insured Person of the Policy shown on this document.

I UNDERSTAND that in order to assess and process my application, HLRA may need information about me, including (but not limited to) medical, financial, legal and employment.

I CONSENT to HLRA obtaining information about me from any Medical Practitioner or health professional that I have consulted at any time and anyone that HLRA wishes to appoint to examine me, legal practitioners, legal tribunals and courts, investigation organisations, accountants or other consultants, HLRA's parent company, other insurance or reinsurance companies, the trustees of my superannuation fund, any organisation appointed by the trustees of my superannuation fund to receive or give information, my past and present employers, and interpreters.

For the purpose of this claim for a benefit and any future claim for a benefit, I also CONSENT to HLRA disclosing information about me to any of the organisations mentioned above, insofar as such disclosures are necessary for HLRA to perform its functions.

SIGN HERE ✗ Life Insured's signature

DD / MM / YYYY Date

Section F – Direct Credit Authority

Completing the details below will assist us in getting your claim payment to you as quickly as possible.

- Once your claim has been assessed, the Benefit Amount payable will be credited to the account below.

BSB number (branch number) ☐☐☐ – ☐☐☐ Account number ☐☐☐☐☐☐☐☐☐

Account name

Financial institution/ name of bank

Branch name/ location of financial institution

Note: If your account is held with a Credit Union, it may take longer for the Benefit Amount payable to be cleared. May we suggest you contact your nominated Credit Union.

SIGN HERE ✗ Life Insured's signature

DD / MM / YYYY Date

- If you don't have an Australian bank account, we will make any claim payment by cheque.

Section G – Checklist

Certified copies of the relevant documentation related to this claim are attached as follows:

What is a certified copy?
This is a signed photocopy of an original document. The person signing it must see the original and the photocopy. It can be signed by a Justice of the Peace, accountant, solicitor, doctor, bank manager or police officer. It means you keep the original.

Income Protection Insurance

☐ The original Policy Document and Policy Schedule.
If these documents have been misplaced, please complete the Statutory Declaration

☐ ▶ **Go to Section H – Statutory Declaration on page 10**

☐ Either, copies of your individual income tax returns and notice of assessments for the previous 2 financial periods or employer issued pay slips for the same period.

☐ A certified copy of proof of the Life Insured's identity (e.g. Birth Certificate, Driver's Licence or Passport).

☐ A completed and signed Medicare Authority form authorising the release of your Medical and Pharmaceutical Benefits Scheme claim information.

Section H – Statutory Declaration

I, (insert name, address and occupation) Name

Address

Occupation

do solemnly and sincerely declare that I am the legal owner/beneficial owner of Policy number Policy number

("Policy") on the life/lives of Life Insured's name
issued by Hannover Life Re of Australasia Ltd ("HLRA").

I have satisfied myself by exhaustive enquiry that for the above Policy, none of the members of my family or my solicitor has any knowledge of the Policy documents' whereabouts nor have they been disposed of by me or to the best of my knowledge by any other person, nor are the Policy documents held by my bank or any other person for safekeeping or lodgement.

The Policy documents have been lost in the following circumstances:

I have not assigned, mortgaged or otherwise dealt with the above Policy in any way and there is no lien on it.

I undertake to return the previous Policy documents to HLRA should they be found.

I make this solemn declaration by virtue of the Statutory Declarations Act 1959 as amended and subject to the penalties provided by the Act for the making of false statements in statutory declarations, conscientiously believing that the statements contained in this declaration are true in every particular.

SIGN HERE ✗ Policyowner/Life Insured's signature — Date: DD / MM / YYYY

Declared at — Date: DD / MM / YYYY

SIGN HERE ✗ Before me (authorised signatory's signature) — Date: DD / MM / YYYY

Full name

Occupation/title

NOTE 1 – A person who willfully makes a false statement in a statutory declaration under the Statutory Declarations Act 1959 as amended is guilty of an offence against the Act, the punishment for which is a fine not exceeding $200 or imprisonment for a term not exceeding six months or both if the offence is prosecuted summarily, or imprisonment for a term not exceeding four years if the offence is prosecuted upon indictment.

NOTE 2 – A statutory declaration under the Statutory Declarations Act 1959 as amended may be made only before a Chief Police, Resident or Special Magistrate; Stipendiary Magistrate or any Magistrate in respect of whose office an annual salary is payable; a Justice of the Peace; a person authorised under any law in force in Australia or its Territories to take affidavits; a person appointed under the Statutory Declarations Act 1959 as amended or under a State Act to be a Commissioner for Declarations; a person appointed as a Commissioner for Declarations under the Statutory Declarations Act 1959, or under that Act as amended, and holding office immediately before the commencement of the Statutory Declarations Act 1959; a Notary Public; a person before whom a statutory declaration may be made under the law of the State in which a declaration is made; or a person appointed to hold, or act in, the office in a country or place outside Australia of Australian Consul-General, Consul, Vice-Consul, Trade Commissioner, Consular Agent, Ambassador, High Commissioner, Minister, Head of Mission, Commissioner, Charge D'Affaires, or Counsel, or Secretary or Attache at an Embassy, High Commissioner's office, Legation or other post.

PART B:
Income Protection Insurance Claim Form – Confidential Medical Report

guardian INSURANCE™

This section is to be fully completed by the registered Medical Practitioner treating the Life Insured.

- Please note that the information required to be completed in this document is in relation to the Life Insured (as indicated below).
- Please note that it is the Life Insured's responsibility for the payment of all fees associated in the completion of this document.
- To ensure that the claim may be assessed fully, and to avoid any delays to this process, please ensure that all the questions in this section are fully addressed and answered.
- If for any reason there is not enough room on this document to provide the details being requested please attach a separate piece of paper and provide the details on this, and also make reference to which item on this document you are addressing. Please ensure that you sign and date the piece of paper.

1. Life Insured's details

First name | Surname

Date of birth (DD / MM / YYYY) | Gender: Male ☐ Female ☐ | Height (cm) | Current weight (kg)

Residential address

2. Medical details

a. Please state the Life Insured occupation/job title:

b. Please detail the date the Life Insured was first ever seen at your medical practice: (DD / MM / YYYY)
(not just for the current medical condition):

c. In the event that the Life Insured was referred to you please detail the name and address of the referring health professional:

First name | Surname

Address

d. What date did the Life Insured consult you in relation to the current medical condition? (DD / MM / YYYY)

e. Please advise the date and nature of the first symptoms related to this condition: (DD / MM / YYYY)

Nature of the first symptoms:

f. Please detail your diagnosis:

g. What process was undertaken in order to come to this diagnosis?
(If tests have been undertaken please attach a copy of all of these)

3. Hospitalisation details

a. If hospitalisation was necessary, please advise:

i) Hospital attended:

ii) Name of treating Medical Practitioner:

iii) Date admitted: DD / MM / YYYY

Date discharged: DD / MM / YYYY

b. Has the insured person ever consulted you, or any other Medical Practitioner, previously for a similar condition or symptoms? If so, please provide dates and doctors consulted:

Doctor	Consultation date
	DD / MM / YYYY
	DD / MM / YYYY
	DD / MM / YYYY
	DD / MM / YYYY
	DD / MM / YYYY

c. Please detail all the current reported symptoms:

d. What specific effect do these symptoms have on the Life Insured's functional work ability?

e. Please detail the last date the Life Insured received any sort of treatment from you for their current medical condition:

f. What date are you next scheduled to treat the Life Insured? DD / MM / YYYY

g. If you have referred the Life Insured to any other medical professional(s) please detail their name, speciality, address and the date of the referral: *If you have received correspondence from other medical professional please attach a copy to this document.*

Name of medical professional	Speciality	Address	Date
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY

h. Please detail what treatment has been provided to date:
If medication has been prescribed please detail the dosage and how often it is to be taken.

i. Is the Life Insured compliant with treatment? No ☐ Yes ☐ ▶ Please detail on what basis you believe this is the case:

j. Please detail the improvements in symptoms (if any) that have been achieved through the treatment to date:

k. If there has not been any improvements in the symptoms to date please detail the reason(s) for this:

l. Please detail the future treatment planned, and objectives hoped to be achieved through this treatment:

m. Please detail your understanding of the Life Insured usual occupation and specific work duties:

a. Occupation:

b. Details of specific work duties:

n. If the current reported symptoms prevent the Life Insured from undertaking their work duties please detail which work duties they are prevented from undertaking and which symptom(s) is preventing this:

Work duties	Symptoms preventing undertaking work duties

o. In your opinion what date did the Life Insured first become unable to undertake their usual occupation due to injury or illness? DD / MM / YYYY

p. What date has the Life Insured reported to you that they totally ceased all work? DD / MM / YYYY

q. Do you consider the Life Insured currently capable of working either full time or part time?

No ☐ Yes ☐ ▶ Please advise from what date, and in what capacity (i.e. full time or part time):

r. If capable of returning to part time work, please advise which duties of their usual occupation the Life Insured is **incapable** of performing?

s. If the Life Insured has not yet returned to work, when do you anticipate they will be able to return: Full Time: DD / MM / YYYY Part Time: DD / MM / YYYY

t. Have you considered, or are you considering, implementing a return to work program or rehabilitation? If so, please provide a copy of the program or details. If not, please detail the reason(s) you don't consider this is an option at this time:

4. Medical Practitioner's final comments

a. Please detail all ongoing medical problems, past history or other circumstances which you are aware are affecting the Life Insured's current condition and ability to work in their usual occupation:

b. Have you given any certificate or report to?

Another Insurance Company:	No ☐	Yes ☐
Workers Compensation Insurer:	No ☐	Yes ☐
Centrelink:	No ☐	Yes ☐
Third Party Insurer:	No ☐	Yes ☐
Solicitor:	No ☐	Yes ☐
Any other party:	No ☐	Yes ☐

If you have answered "yes" to any of the above, please detail the name of the organisation you have provided this information to and their address:

c. Please provide us with any other comments you may have to assist the Life Insured to return to good health and return to work:

5. Medical Practitioner's declaration and agreement

I hereby certify that I have personally attended to the Life Insured named on page 1 and that all the information supplied by me in this Report is true. I agree that the Insurer may provide copies of this Report to any medical specialist from whom Hannover Life Re of Australasia Ltd ("HLRA") seeks an independent report or to any other person deemed necessary to assist in the assessment of this claim, or to any other person or organisation to whom HLRA is obligated under the Privacy Act 1988 to give access to this Report.

Name			
Qualifications			
Address			
Telephone		Facsimile	
Email			

SIGN HERE

✗ Medical Practitioner's signature

DD / MM / YYYY Date