ACC 18

Medical certificate

B

1. PATIENT DETAILS

Patient to complete

ACC45/CLAIM NO:

NHI No

Family name

TITLE (MR/MRS/MISS/MS)

First name(s)

Date of birth (DAY / MONTH / YEAR)

Date of accident (DAY / MONTH / YEAR)

Residential address (NO. AND STREET / SUBURB / CITY/TOWN / POSTCODE)

Phone **WORK** (CODE) **HOME/MOBILE** (CODE)

Email address

2. INJURY DETAILS

Provider to complete all questions

Principal diagnosis code: Side: ○ Left ○ Right ○ Not applicable

Description:

Second diagnosis code: Side: ○ Left ○ Right ○ Not applicable

Description:

3. FITNESS FOR WORK

Provider to complete all options that apply

○ The patient is **fit to return to work** on (DAY / MONTH / YEAR)

○ The patient is **fit for some work** from (DAY / MONTH / YEAR) to (DAY / MONTH / YEAR)

○ Normal hours **OR** ○ (HOURS) per day (DAYS) per week

During this time period, the patient has the following physical restrictions:

○ Prolonged standing ○ Prolonged sitting ○ Prolonged walking ○ Driving ○ Posture
○ Lifting/forceful movements ○ Heavy physical work ○ Repetition ○ Temperature ○ Vibration

Other restriction details

○ The patient is **fully unfit for work** from (DAY / MONTH / YEAR) to (DAY / MONTH / YEAR)

because

Date of next review (DAY / MONTH / YEAR)

4. OTHER ASSISTANCE

Provider to complete

If return to work assistance is required, please indicate which is needed:

○ Support needed to stay at work/return to work ○ ACC to contact me

Describe any complications or other issues affecting recovery or rehabilitation:

Describe any other assistance the patient needs to discuss with a case manager, eg equipment, home help, transport:

5. DECLARATION

Provider to complete all questions

Doctor name NZMC/NZNC no.

Practice/address

ACC PROVIDER ID ACC VENDOR ID ACC FACILITY ID

I personally examined the patient named above for the above injury(s) and to the best of my knowledge, the information given is accurate.
I can confirm that:

- I've discussed the patient information on the reverse of this form with the patient
- The patient agrees that this certificate is an accurate reflection of their activity restrictions
- The patient authorises ACC to collect the following information and to use and disclose it in accordance with the purposes set out in the patient information:
  - Medical and other records which are or may be relevant to their claim
  - Details of their accident
  - Tax records, employment details and history which are or may be relevant to their claim
- The patient authorises the holders of such information to provide it to ACC
- The patient has authorised me to send this form to ACC.

Doctor signature: Date: (DAY / MONTH / YEAR)

ACC copy: Please return to ACC Hamilton Service Centre, PO Box 952, Waikato Mail Centre 3240 or email to claimdocs@acc.co.nz.

You must send this copy to ACC before we can pay you any weekly earnings compensation.

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Medical certificate

B

1. PATIENT DETAILS

Patient to complete

ACC45/CLAIM NO:

NHI No

Family name

TITLE (MR/MRS/MISS/MS)

First name(s)

Date of birth DAY MONTH YEAR

Date of accident DAY MONTH YEAR

Residential address NO. AND STREET SUBURB CITY/TOWN POSTCODE

Phone **WORK** O CODE **HOME/MOBILE** O CODE

Email address

2. INJURY DETAILS

Provider to complete all questions

Principal diagnosis code:

Side: ○ Left ○ Right ○ Not applicable

Description:

Second diagnosis code:

Side: ○ Left ○ Right ○ Not applicable

Description:

3. FITNESS FOR WORK

Provider to complete all options that apply

○ The patient is **fit to return to work** on DAY MONTH YEAR

○ The patient is **fit for some work** from DAY MONTH YEAR to DAY MONTH YEAR

○ Normal hours **OR** ○ HOURS per day DAYS per week

During this time period, the patient has the following physical restrictions:

○ Prolonged standing ○ Prolonged sitting ○ Prolonged walking ○ Driving ○ Posture

○ Lifting/forceful movements ○ Heavy physical work ○ Repetition ○ Temperature ○ Vibration

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○ The patient is **fully unfit for work** from DAY MONTH YEAR to DAY MONTH YEAR

because

Date of next review DAY MONTH YEAR

4. OTHER ASSISTANCE

Provider to complete

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Doctor signature:

Date: DAY MONTH YEAR

GP copy: please keep this copy for your patient's file

ACC 18

Medical certificate

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1. PATIENT DETAILS

Patient to complete

ACC45/CLAIM NO:

NHI No

Family name _____ First name(s) _____

TITLE (MR/MRS/MISS/MS)

Date of birth DAY MONTH YEAR

Date of accident DAY MONTH YEAR

Residential address _____ _____ _____

NO. AND STREET SUBURB CITY/TOWN POSTCODE

Phone **WORK** O CODE **HOME/MOBILE** O CODE

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2. INJURY DETAILS

Provider to complete all questions

Principal diagnosis code: Side: ○ Left ○ Right ○ Not applicable

Description: _____

Second diagnosis code: Side: ○ Left ○ Right ○ Not applicable

Description: _____

3. FITNESS FOR WORK

Provider to complete all options that apply

○ The patient is **fit to return to work** on DAY MONTH YEAR

○ The patient is **fit for some work** from DAY MONTH YEAR to DAY MONTH YEAR

○ Normal hours **OR** ○ HOURS per day DAYS per week

During this time period, the patient has the following physical restrictions:

○ Prolonged standing ○ Prolonged sitting ○ Prolonged walking ○ Driving ○ Posture

○ Lifting/forceful movements ○ Heavy physical work ○ Repetition ○ Temperature ○ Vibration

Other restriction details _____

○ The patient is **fully unfit for work** from DAY MONTH YEAR to DAY MONTH YEAR

because _____ Date of next review DAY MONTH YEAR

4. OTHER ASSISTANCE

Provider to complete

If return to work assistance is required, please indicate which is needed:

○ Support needed to stay at work/return to work ○ ACC to contact me

Describe any complications or other issues affecting recovery or rehabilitation: _____

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Doctor signature: _____ Date: DAY MONTH YEAR

Patient copy: please keep this copy and read the important information on the back

PATIENT Important information

ACC is here to support you if you've been injured, by helping you get back to work and everyday life as soon as possible. If you need time off work after an accident, or your normal activities are limited, we will help in your recovery.

This ACC18 Medical Certificate describes how your injury affects your ability to work. If ACC needs any more information about your claim we will contact you later.

Getting the right treatment and payments

To make sure you receive the right treatment and any payments for your claim, it's important that all the information on this ACC18 Medical Certificate is accurate.

So that you always receive the right help, it's important you let us know if:

- you return to work or receive any earnings, no matter how small, so we can adjust your weekly compensation payments.
- there's any change in your physical capacity.
- the services being provided by ACC are not being delivered properly, e.g. if your home helper doesn't turn up.

It's your responsibility to let us know about any changes to your personal circumstances that may affect your payments. Please help us keep the ACC scheme fair for everyone by keeping your information accurate. If we find the information supplied is false we will take the matter seriously.

Resolving issues

If you have concerns about a decision we've made or the service we have provided, get in touch to talk this through. We will work with you to resolve things as quickly as possible. More information about your options for resolving concerns, including reviews, can be found here www.acc.co.nz/resolve-an-issue

About the ACC18 form

- Please keep your copy of this form.
- This form may also be used by accredited employers in the ACC Partnership Programme.

Collecting and using your personal information

ACC collects your personal and health information to assess whether your claim is covered under the ACC scheme, to manage your claim, and to assess and provide appropriate rehabilitation, treatment, and compensation to you. We also use personal information for other lawful purposes connected with our functions and activities under the Accident Compensation Act 2001 (including research, policy development, maintaining a claims database, systems testing, levy setting, internal processes including investigations, training and processing information requests).

ACC may need to obtain medical and other records about you from third parties such as your general practitioner (GP), specialists, other medical professionals or treatment providers, or your employer.

Providing information to ACC is voluntary. However, if relevant information is not provided, ACC may not be able to determine whether you are eligible for cover or for particular entitlements.

Under the Accident Compensation Act 2001, you must provide information that is relevant to your claim when ACC reasonably requires you to provide it. ACC may decline to provide any entitlement if you unreasonably refuse to give ACC any relevant information or to authorise ACC to obtain records that may be relevant to your claim.

ACC shares personal and health information with other agencies for the purposes of managing claims and entitlements, to fulfil our other statutory functions, and in other situations where permitted or required by law. These agencies include government agencies, external providers (e.g. treatment providers) and your employer (including for non-work related injuries).

You have the right to access and request correction of personal and health information that ACC holds about you.

The Privacy Act 2020 and the Health Information Privacy Code 2020 apply to your personal and health information. Further details of how and why we collect, use, store and disclose information are set out in our Privacy notice which may be viewed on our website:

www.acc.co.nz/privacy/our-privacy-notice/.

For more information about privacy, to request access or correction of your personal and health information, or if you have a question or concern, contact us: privacy.officer@acc.co.nz

The Privacy Officer, Accident Compensation Corporation, PO Box 242, Wellington 6011

PATIENT AUTHORISATION

I authorise:

- ACC to collect medical and other records which are or may be relevant to my claim
- the treatment provider to lodge this claim for me.

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1. PATIENT DETAILS

Patient to complete

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NHI No

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Other restriction details

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  - Tax records, employment details and history which are or may be relevant to their claim
- The patient authorises the holders of such information to provide it to ACC
- The patient has authorised me to send this form to ACC.

Doctor signature:

Date: (DAY / MONTH / YEAR)

Employer copy: please give this copy to your employer