



1. PATIENT DETAILS Patient to compl	lete B
ACC45/CLAIM NO:	NHI No L
Family name	First name(s)
Date of birth	Date of accident
DAY MONTH YEAR Residential address	DAY MONTH YEAR
Phone WORK O	SUBURB CITY/TOWN POSTCODE
Email address	
2. INJURY DETAILS Provider to compl	lete all questions
Principal diagnosis code: Description:	Side: O Left O Right O Not applicable
Second diagnosis code:	Side: O Left O Right O Not applicable
3. FITNESS FOR WORK Provider to a	complete all options that apply
• The patient is fit to return to work on	O The patient is fit for some work from
DAY MONTH YEAR	DAY MONTH YEAR
O Normal hours OR O per day per w	veek
During this time period, the patient has the following physical res	
O Prolonged standing O Prolonged sitting	O Prolonged walking O Driving O Posture
 Lifting/forceful movements O Heavy physical work Other restriction details 	Repetition O Temperature O Vibration
O The patient is fully unfit for work from	
DAY	MONTH YEAR DAY MONTH YEAR
because	Date of next review Day MONTH YEAR
4. OTHER ASSISTANCE Provider to	
If return to work assistance is required, please indicate which is r	
O Support needed to stay at work/return to work Describe any complications or other issues affecting recovery or	○ ACC to contact me
Describe any other assistance the patient needs to discuss with	a case manager, eg equipment, home help, transport:
5. DECLARATION Provider to complete al	
Doctor name Practice/address	NZMC/NZNC no.
	ACC FACILITY ID
 ACC PROVIDER ID I personally examined the patient named above for the above injuto 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 the patient The patient agrees that this certificate is an accurate reflection their activity restrictions The patient authorises ACC to collect the following information to use and disclose it in accordance with the purposes set of 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:
ACC conv. Please return to ACC Hamilton Service Cent	tre PO Box occ. Waikato Mail Centre 2240 or email to claimdocs@acc.co.nz

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.



Medical certificate



Acces/cLAIM Mor	1. PATIENT DETAILS Patient to complete	В		
First name(s)	ACC45/CLAIM NO:			
Date of birth	Family name			
Phone WORL Output Output Phone Output Phone WORL Output Phone <	Date of birth			
Jump Jump Enail address	Residential address	JRB CITY/TOWN POSTCODE		
2. NJURY DETAILS Provider to complete all questions Principal diagnosis code:				
Principal diagnosis code:	Email address			
Description: Second diagnosis code: Description: Second diagnosis code: Second diagnosi: Second dia	2. INJURY DETAILS Provider to complete all	questions		
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Image: Second	3. FITNESS FOR WORK Provider to complet	e all options that apply		
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5. DECLARATION Provider to complete all questions Doctor name NZMC/NZNC no. Practice/address				
Doctor name NZMC/NZNC no. Practice/address	Describe any other assistance the patient needs to discuss with a case	manager, eg equipment, home help, transport:		
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Doctor signature Date Date Date Month Year	Doctor signature:			



Medical certificate



1. PATIENT DETAILS Patient to a	complete B	
ACC45/CLAIM NO:		
Family name	First name(s)	
Date of birth	Date of accident	
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NO. AND STREET		
Phone WORK O		
Email address		
2. INJURY DETAILS Provider to	complete all questions	
Principal diagnosis code:	Side: O Left O Right O Not applicable	
Second diagnosis code:	Side: O Left O Right O Not applicable	
3. FITNESS FOR WORK Provide	er to complete all options that apply	
O The patient is fit to return to work on	O The patient is fit for some work from	
DAY MONTH YEAR	DAY MONTH YEAR	
O Normal hours OR O per day pays		
During this time period, the patient has the following physi		
 O Prolonged standing O Lifting/forceful movements O Heavy physica 		
Other restriction details		
O The patient is fully unfit for work from	AY MONTH YEAR TO DAY MONTH YEAR	
because	Date of next review	
4. OTHER ASSISTANCE Provid	day month year der to complete	
If return to work assistance is required, please indicate whi	ich is needed:	
\bigcirc Support needed to stay at work/return to work	○ ACC to contact me	
Describe any complications or other issues affecting recov	/ery or rehabilitation:	
Describe any other assistance the patient needs to discuss	s with a case manager, eg equipment, home help, transport:	
5. DECLARATION Provider to comp	lete all questions	
Doctor name	NZMC/NZNC no.	
Practice/address		
ACC PROVIDER ID	OR ID	
 I personally examined the patient named above for the above to the best of my knowledge, the information given is accurate a confirm that: I've discussed the patient information on the reverse of the patient The patient agrees that this certificate is an accurate reactivity restrictions The patient authorises ACC to collect the following information to use and disclose it in accordance with the purposes patient information: 	 ate. 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: L _ L L _ L L _ L L _ L L _ L L _ L L _ L L _ L L _ L L _ L L _ L L _ L L _ L L _ L L _ L L _ L L _ L L _ L L _ L L _ L _ L L _ L _ L L _ L _ L L _ L _ L L _ L _ L _ L L _ L L _ L _ L _ L _ L _ L _ L L _ L _ L _ L _ L L _ L L	
	DAY MONTH YEAR	

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.



Medical certificate



1. PATIENT DETAILS Patient to complete	В			
ACC45/CLAIM NO:				
Family name	First name(s)			
Date of birth	Date of accident A MONTH YEAR			
Residential address	RB CITY/TOWN POSTCODE			
Phone WORK O HOM	E/MOBILE O			
Email address				
2. INJURY DETAILS Provider to complete all q	questions			
Principal diagnosis code: L	Side: O Left O Right O Not applicable			
Second diagnosis code:	Side: O Left O Right O Not applicable			
3. FITNESS FOR WORK Provider to complete	e all options that apply			
	The patient is fit for some work from			
	DAY MONTH YEAR TO DAY MONTH YEAR			
O Normal hours OR O L per day L per week				
During this time period, the patient has the following physical restrictions				
O Lifting/forceful movements O Heavy physical work	Prolonged walking O Driving O Posture Repetition O Temperature O Vibration			
Other restriction details				
O The patient is fully unfit for work from	Year DAY MONTH YEAR			
because	Date of next review			
4. OTHER ASSISTANCE Provider to comple	te			
If return to work assistance is required, please indicate which is needed:				
	⊖ ACC to contact me			
Describe any complications or other issues affecting recovery or rehabili	tation:			
Describe any other assistance the patient needs to discuss with a case manager, eg equipment, home help, transport:				
5. DECLARATION <i>Provider to complete all question</i>	ons			
Doctor name	NZMC/NZNC no.			
Practice/address				
ACC PROVIDER 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 wit 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: 	 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:			