



Department of Social Insurance

MEDICAL CERTIFICATE
For Social Insurance Purposes Only

To claim benefit complete this form, sign it, and return it without delay to the Department of Social Insurance. You may lose benefit if you do not claim promptly.

This form must be completed by the Medical Practitioner.

Name	1. What is the client's name?
	First Name(s)
	Surname or family name
	Date of Birth (mm/dd/yyyy)

Disability details	2. Does the person have a disability that prevents them from working?
	☐ Yes ☐ No
	3. What is the nature of the disability? (check and explain below)

☐ Psychological or Psychiatric	☐ Immune System Disorders
☐ Nervous System Disorders	☐ Metabolic and Endocrine Disorders
☐ Cardiovascular Disorders	☐ Accident
☐ Sensory Disorders	☐ Other (Please explain)

Explain:

4. Please indicate the expected duration of the disability:
☐ Less than 6 months : There may be no entitlement to Disability
☐ 6 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ permanent
4a. He/she became incapacitated for work on (date)

5. Please confirm date of last doctor's visit

Month	Day	Year
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GOVERNMENT OF BERMUDA
Ministry of Finance

Department of Social Insurance

Registered
Medical
Practitioner’s
Verification

Please print your details below
Medical Practitioner’s full name

Practice name and full address

Telephone number

Medical Practitioner’s signature

Day Month Year

I declare that because of incapacity, I have not worked since the date of the last medical certificate furnished by me and the information given is true and complete.

Applicant’s Signature.

Day Month Year

Privacy: The person has been advised and understands that this information is required for benefit assessment purposes.