WCP 5

WORKERS COMPENSATION FUND
DUTY EXEMPTION FORM

(This form shall be filled by a medical practitioner)

A. Occupational accident/ disease (Mark (√) appropriately)

Occupational accident		Occupational disease	

B. Patient (employee) identification

Med treatment file No.	Name of the patient	Sex	Date of birth	ID No./Code No.

C. Occupational particulars of the patient (employee)

Company name and address	Department/Section	Job tittle	Actual activities (major day to day occupational activities)

D. Functional status assessment (Mark (√) appropriately)

No functional loss	Functional loss	Grade of functional loss if any

E. Medical practitioner's remarks

F. Employee fitness to work status (Mark (√) appropriately)

Fit with restrictions (should be based on D & E above)	Unfit (should be based on D & E above)

G. Medical practitioner's decision

Decision	No. of days	Reasons
Excuse duty(ED)		
Light duty (LD)		

H. Medical practitioner's particulars

Name and Address of the health care provider ……………………………………………………………………………………………….

Name of the Medical practitioner…………………………………………………………………………..Reg No.………………………...

Designation……………………………….. Date…………………………

Signature and Official stamp ……………………………………………………………………………...

Kindly note:

- If Excuse Duty (ED) more than three days relevant consultant needs to sign
- The above Excuse Duty (ED) is only valid if all sections are adequately filled.