



CSS Medical examination report for invalidity retirement

Contributor under the *Superannuation Act 1976*

Appointment details (to be completed by employer)

MEMBER'S NAME							
Surname	<input type="text"/>						
Given name/s	<input type="text"/>						
You are requested to report for examination as follows:							
Date	<table> <tr> <td>DAY</td> <td>MONTH</td> <td>YEAR</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>	DAY	MONTH	YEAR	<input type="text"/>	<input type="text"/>	<input type="text"/>
DAY	MONTH	YEAR					
<input type="text"/>	<input type="text"/>	<input type="text"/>					
Time	<table> <tr> <td><input type="text"/></td> <td>:</td> <td><input type="text"/></td> <td>AM / PM</td> </tr> </table>	<input type="text"/>	:	<input type="text"/>	AM / PM		
<input type="text"/>	:	<input type="text"/>	AM / PM				
Place	<input type="text"/>						

Important information for scheme members/employers

The circumstances in which the medical examination should proceed are discussed in detail below. Please read them carefully.

Information for employers

- > Medical examination must be undertaken by one of our approved medical practitioners. (AMP)
- > The employer should complete the appointment details on the front page and the details in Sections A and B of the form.
- > The employer should attach relevant reports, including details of current and former duties, health assessment reports, and any rehabilitation program undertaken.
- > Up-to-date treating specialists/doctors reports are required in all cases.
- > The employer should hand these first two pages to the member and send the remainder of the form, plus attachments, to the AMP, in time for the examination.

Information for scheme members

- > The purpose of this medical examination is:
 - > to assess your current health status; and
 - > to enable the examining physician to express an opinion on whether you are, or are likely to become, totally and permanently incapacitated.
- > You should attend for the medical examination at the time specified.
- > You have the right to submit supporting evidence to the doctor conducting the examination.
- > At the medical examination you will be asked to sign both a declaration that you have read this information sheet and an authority to exchange medical information.

Information from this examination will be used by your employer to assist in deciding whether an application for invalidity retirement should be made. If an application is made, the information will be used by ARIA to assist in determining whether an invalidity retirement certificate should be granted to allow you to be paid invalidity benefits. In this regard, the application will be referred to an assessment panel engaged by ARIA to provide a recommendation on whether you can be considered to be totally and permanently incapacitated.

Personal information is treated as confidential and can only be released where relevant legislation allows.

Evidence obtained for the purpose of the invalidity process may be referred to any doctors or service providers who are asked to examine and/or provide reports concerning the member, to assist in the examination and report-writing. Copies of evidence obtained by us may be provided to the employer, unless otherwise restricted, to assist in establishing future employment prospects.



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Medical examination report form

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SECTION A - Personal and employment details

(to be completed by employer)

Title (please tick one)	<input type="checkbox"/> Mr	<input type="checkbox"/> Ms	<input type="checkbox"/> Mrs	<input type="checkbox"/> Miss	<input type="checkbox"/> Other	<input type="text"/>
MEMBER'S NAME Surname	<input type="text"/>					
Given name/s	<input type="text"/>					
Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female				
Date of birth	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
Reference (AGS) number	<input type="text"/>					
Date joined scheme	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
Designation and classification	<input type="text"/>					
Date on which continuous sick leave commenced	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
Is the person in receipt of compensation benefits in respect of the illness or injury?	<input type="checkbox"/> YES	<input type="checkbox"/> NO				
Has the person made an application for compensation benefits?	<input type="checkbox"/> YES	<input type="checkbox"/> NO				
Employer	<input type="text"/>					
Employer contact officer	<input type="text"/>					
Contact phone number	<input type="text"/>	<input type="text"/>				
Address of Employer	<input type="text"/>					
	<input type="text"/>					
	<input type="text"/>					
STATE	<input type="text"/>	POSTCODE				
	<input type="text"/>	<input type="text"/>				

SECTION E - Examining physician's report and assessment

Examining Physicians must provide a typewritten report and assessment, addressing all of the following:

- Current complaint/diagnosis
- History (both occupational and medical)
- Clinical findings
- Assessment (including review of reports/social factors/discussions with personnel staff. Please identify any apparent inconsistency).

List any additional documentation obtained and ATTACH it to this form

Date of Report	Doctor's Name	Specialty

After clinical examination, medical tests and specialist tests as appropriate, I consider that the member is suffering from the following medical condition(s). Please indicate on a scale of 1 to 10 the degree of incapacity for each condition (10 = total incapacity).

CONDITION	SCALE	ICD CODE TO BE INSERTED
1. <input type="text"/>	<input type="text"/>	<input type="text"/>
2. <input type="text"/>	<input type="text"/>	<input type="text"/>
3. <input type="text"/>	<input type="text"/>	<input type="text"/>
4. <input type="text"/>	<input type="text"/>	<input type="text"/>

SECTION F - Examining physician's recommendations

Any recommendations made below must be supported by reasons in the body of the report. If the recommendations are not supported this form will be returned for completion.

1. Is the member medically fit to resume all duties of his/her current position? YES NO
2. Is a further period of sick leave the best course of action? YES NO
 - If YES, 2a To what date should further sick leave be granted?

DAY	MONTH	YEAR
<input type="text"/>	<input type="text"/>	<input type="text"/>
 - 2b What treatment/rehabilitation program should the member be undertaking while on sick leave?

Section F continued over page

Section F continued

3. Should the member be considered for modified duties or reduced hours in his/her current position? YES NO

If YES, 3a What modification to current duties do you recommend?

3b Specify recommended hours of duty?

PERMANENTLY/TEMPORARILY UNTIL										
DAY			MONTH			YEAR				
			/			/				

3c For how long are alternative duties required?

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Partial invalidity pension may be payable in these circumstances

4. Should the member be considered for alternative duties in another position in either the public or private sector? YES NO

If YES, 4a What alternative duties do you recommend?

4b For how long are alternative duties required?

PERMANENTLY/TEMPORARILY UNTIL										
DAY			MONTH			YEAR				
			/			/				

5. Could treatment or a rehabilitation program prevent the member's total and permanent incapacity? YES NO

If YES, 5a What treatment or rehabilitation program do you recommend?

6. Do you consider that there is a likelihood that the member will be totally and permanently incapacitated and, if so, that the case should be referred to ARIA for further consideration? YES NO

7. Is the member's medical condition of a terminal nature such that:

7a life expectancy is less than 12 months; or YES NO

7b of such severity that, within the next 2 years, he/she will require assistance with personal or nursing care on a daily basis? YES NO

8. Is there evidence that the member's incapacity is due to wilful action on the part of the member to obtain an invalidity benefit? YES NO

