

Health insurance company or payer		
Surname, first name of the insured person		
		born on
Cost object identifier	Insured person no.	Status
Business premises no.	Doctor number	Date

# Certificate of disability

1

- ☐ Initial certificate
- ☐ Follow-up certificate

☐ Accident at work, consequences of accident at work, occupational disease

☐ Assigned to the transit doctor

Unable to work since

--	--	--	--	--	--

Expected incapacity until last day of work.

--	--	--	--	--	--

Determined on

--	--	--	--	--	--

Contract doctor's stamp/signature of the doctor

Copy for submission to the Health Insurance

## Diagnosis(s) justifying AU (ICD-10)

ICD-10 - Code	ICD-10 - Code	ICD-10 - Code
ICD-10 - Code	ICD-10 - Code	ICD-10 - Code

- ☐ Other accident outcomes
- ☐ Pension problems (e.g. BVG)

## Special measures required.

- ☐ Services for medical rehabilitation
- ☐ Gradually Reintegration

☐ Other

For sick pay cases. ☐ From the 7th week or other sick pay instances. ☐ Final certificate