

**FW03MP**

FIJI NATIONAL PROVIDENT FUND  
EMPLOYMENT BOARD



## CONFIDENTIAL MEDICAL CERTIFICATE

### APPLICATION FOR WITHDRAWAL BY A MEMBER WHO IS PHYSICALLY / MENTALLY INCAPACITATED FROM EVER ENGAGING IN ANY FURTHER EMPLOYMENT

**Please read these notes:**

This form must be immediately sent to FNPf on completion of examination.

**1. Who completes this application form.**

- \* This Form (**FW03MP**) has to be completed by a registered Medical Practitioner authorised by the FNPf Board under **Section 54 of the FNPf Act 2011**.
- \* All doctors registered under Part 2 of the Medical Practitioners Act and who are in charge of government dispensaries.
- \* All consultants attached to district hospitals.

Head Office	Lautoka	Labasa	Sigatoka Branch	Nadi Agency	Savusavu Agency	Ba Agency	Valelevu Agency	Nausori Branch
Provident Plaza 2 Private Mail Bag, Suva Telephone: (679) 330 7811 Facsimile: (679) 330 7611	Shop 5, Provident Centre, 6 Naviti Street, Private Mail Bag, Lautoka Telephone: (679) 666 1888 Facsimile: (679) 666 5232	Rosawa Street Private Mail Bag, Labasa Telephone: (679) 881 2111 Facsimile: (679) 881 2741	Shop 3-4, Hanif Building, Matamata Subdivision Phone: (679) 666 1888	Shop 2, Lot 13 Concave Subdivision Namaka Lane, Nadi Telephone: (679) 323 8018, 323 8006 Facsimile: (679) 672 8982	Budget Lodge Building Ltd Main Street, Savusavu Telephone: (679) 885 3396 Facsimile: (679) 885 3397	Ganga Singh Street, Ba Telephone: (679) 667 0009 Facsimile: (679) 323 8007	Shop 3, Rajendra Prasad Bros Supermarket Complex Valelevu Complex Building Saqa Place, Valelevu Telephone: (679) 3343 671 Facsimile: (679) 3343 670	Lot 1, Main Street, Nausori Telephone: (679) 323 8030, (679) 323 8031

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# CONFIDENTIAL MEDICAL CERTIFICATE

on the health, constitution and prospects of further employment of:-

Mr/Mrs/Miss \_\_\_\_\_

**Please read these notes:**

- | This form must be sent to FNPF immediately on completion of examination.
- | Information regarding your findings should not be disclosed to the above named or to any other person.
- | If you think certain examinations are not necessary you may so indicate.

1. Are you personally or professionally acquainted with the above named person? If so, for how long.

2. Is there anything unfavorable in his appearance or development

Give the following measurements

3. Height (without shoes)

 cm

4. Weight (Clothed)

 kg

5. Is there any abnormality of the respiratory system due to palpation, percussion or auscultation? If so give particulars.

6. Rate, rhythm and character of the pulse?

Pulse rate  per min. Rhythm  Character

7. Position of the apex beat of the heart?

In the  Interspace  centimeters from mid-sternal line.

8. Is there evidence of cardiac enlargement?

9. Is there any abnormality of the heart sounds or rhythm? If so give particulars.

10. If any murmur is present describe fully site, timing intensity and transmission

11. Also indicate any effect on posture or respiration on the murmur

**BLOOD PRESSURE**

12. Systolic

13. Diastolic

**IS THERE ABNORMALITY?**

14. Ears/Nose/Throat

15. Is there any abnormality or evidence of disease of any abdominal organs including liver and spleen: If so give particulars.

16. Is there any abnormality of lymph glands in the neck, axillae or inguinal region? If so give particulars.

17. Examination of urine

The urine should be passed at the time of examination. If not, please state circumstances

(a) Albumin?

(b) Sugar?

18. Is there any abnormal reflex or other evidence of disease of the cranial nerves or spinal cord? If so, give particulars.

19. Is there any defect in sight, hearing or speech? In cases of present or past ear discharge or deafness. State result of fundoscopic, auroscopic examination.

20. Is there any abnormality of the Joints? If so, describe fully and provide relevant evidence (attach x-ray report)

21. Diagnosis (Block Letters)

22. Provide relevant evidence to support diagnosis (attach report)

23. Do you consider the above named person to be physically/mentally incapacitated from ever engaging in any further employment?

24. If so, disclose the reasons that you suggest should be taken into account by FNPF in considering withdrawal of contributions.

Name (Medical Examiner)

Date

Address

Signature

Email

Phone

## DECLARATION

- (a) I understand that I am responsible for the confidentiality of information received through the preferred communication medium. I hereby indemnify the Fund from any liability whatsoever, including the loss of privileged information received through the preferred communication medium.
- (b) I declare that the information as given on this application is true and correct and that I have not withheld any information concerning my health and medical history. I for myself, my executors or administrators, notwithstanding any rule of law or conduct concerning disclosure of information, irrevocably authorise and direct any Medical Practitioner or other person whether herein named or not, to divulge at any time to the FNPF to any Legal Board before which any question concerning the withdrawal of contributions shall arise, any information concerning my health and medical history which he may at any time hereafter acquire.

Signature (Applicant)

Date

Signature of witness (Medical Examiner)

Name of Witness (Medical Examiner)

Medical Examiner Stamp