Form MC_5

INVALIDITY CERTIFICATE

To be completed by Medical Practitioner

WARNING: Any person who knowingly makes a false representation for the purpose of obtaining a benefit commits a criminal offence punishable by a fine or imprisonment or both.

To: **Director**
Montserrat Social Security

Date of Birth | | | | | | | (dd mm yy)

Full Name Mr. / Mrs. / Miss. .....

I hereby certify that on | | | | | | | (dd mm yy) I examined the above named person and he / she is suffering from .....
and his / her condition is such that he / she :

Please tick appropriate box

☐ Can be gainfully employed at this point in time

☐ Cannot be gainfully employed at this point in time

Any other remarks .....

.....

It is my opinion he / she will be fit to resume employment on .....

I declare that the foregoing information given above is true and accurate to the best of my knowledge and belief.

Name of Medical Practitioner .....

Signature of Medical Practitioner .....

Addresss .....

.....

Date | | | | | | | (dd mm yy)

Doctor's stamp / Registration No.

NOTE: For the purpose of Benefit Regulations "INVALID" means the person is incapable of being gainfully employed as a result of a specific disease or bodily or mental disablement. Gainfully employed in this instance means Insured Person is capable of performing work for which renumeraion is or would ordinarily be payable.

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