

7	Detailed treatment plan, with date of hospital admission and proposed procedure(s), name of hospital and estimated costs and the codes to be used. (Please attach a separate page with this information, if the space provided is not enough.)
8.	How will the proposed treatment reduce the disablement the employee is suffering from?
9.	Other health team members who will be involved during the procedure / treatment.

I certify that I have by examination, satisfied myself that the condition of the employee is the result of the accident as described above.

Signature of Medical Practitioner		Practice number	
Name (Printed)		Date (important)	
Dr's telephone number	e-mail address	Fax number	Cell
Address			
Signature of the employee		Date(important)	
Employee's contact number			

DOCTORS NAME STAMP.....