SB MEDICAL CERTIFICATE OF INCAPACITY FOR WORK - ELECTRONIC 2020

To be completed by Registered Medical Practitioner ***(Certificate to be filled in English and must be legible)***

Name of Insured Person: ____
(Enter name as per Social Security Card) FIRST MIDDLE SURNAME

Social Security No: | | | | | | | | | | Email/ Phone: ____________________

Name of Employer: ____________________ Employer's Email/Phone #: ____________________

I certify that the above person is incapable of work due to the medical condition for the period stated below:

a) Diagnosis

i) Primary Diagnosis ______________________________ ICD10 Code ____________

b) Period of Incapacity From: _____ /_____ /_____ To: _____ /_____ /_____
DAY MONTH YEAR DAY MONTH YEAR

c) Date of Examination _____ /_____ /_____
DAY MONTH YEAR

Medical Practitioner: ____
(BLOCK LETTERS) FIRST MIDDLE SURNAME

or GOB Approved Medical Officer ☐

Medical Council of Belize Registration No. ____________________

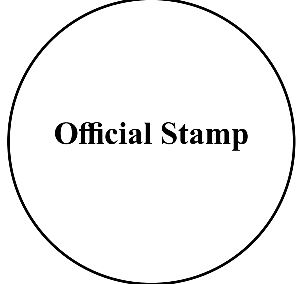
Date: _____ /_____ /_____
DAY MONTH YEAR

Digital Signature of Medical Practitioner: ____________________

Name of Institution: ____________________

Address of Institution: ____________________

Physician Comments: ____________________



FOR OFFICIAL USE ONLY

Decision on Sickness Benefit Claim

(i) Allowed Period of Benefit **Allowed From:** _____ /_____ /_____ To: _____ /_____ /_____
DAY MONTH YEAR DAY MONTH YEAR

Weekly Benefit Rate: $ ____________ Amount Payable: $ ____________

(ii) Disallowed Period of Benefit **Disallowed From:** _____ /_____ /_____ To: _____ /_____ /_____
DAY MONTH YEAR DAY MONTH YEAR

ISCO Code: ____________________

If disallowed, state the reasons for disallowance:

____

ISCO Code: ____________________

Reason for deductions, if any: ____________________