



## 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 (**FNPf 10**) has to be completed by a registered medical practitioner authorised by the FNPf Board under **Regulation 62 of the FNPf Act cap 219**.
- \* 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.

All Correspondence to be addressed to the General Manager & Chief Executive

**Head Office**

Provident Plaza 2  
Private Mail Bag  
Suva  
Telephone: (679) 330 7811  
Facsimile: (679) 330 7611

**Lautoka**

Drasa Avenue  
Private Mail Bag  
Lautoka  
Telephone: (679) 666 1888  
Facsimile: (679) 666 5232

**Labasa**

Rosawa Street  
Private Mail Bag  
Labasa  
Telephone: (679) 881 2111  
Facsimile: (679) 881 2741

**Valelevu Agency**

Valelevu Complex Building  
Saqa Place  
Valelevu  
Telephone: (679) 3343 671  
Facsimile: (679) 3343 670

**Nadi Agency**

Shop 2 Lalidhar Arcade  
Namaka Lane  
Nadi  
Telephone: (679) 672 8981  
Facsimile: (679) 672 8982

**Savusavu Agency**

Budget Lodge Building Ltd  
Main Street  
Savusavu  
Telephone: (679) 885 3396  
Facsimile: (679) 885 3397

**Ba Agency**

Ganga Singh Street, Ba  
Telephone: (679) 667 0003

# 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

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

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

18. Examination of urine

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

(a) Albumin?

(b) Sugar?

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

20. 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.

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

  

22. Diagnosis (Block Letters)

  
  

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

  

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

25. 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

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)

