



MEDICAL PRACTITIONER FORM

PARTICULARS OF CLIENT Name: _____ Address: E-Mail address: _____ Telephone number: Identity number: PARTICULARS OF MEDICAL PRACTITIONER _____ (practice or HPCSA No) _____ Address E-Mail address Telephone number _____ (medical practitioner's full name), identity number ____and practice number or HPCSA number _____ do hereby declare the following: 1. I am a qualified medical practitioner and qualified and practicing specialist in _____ (state area of speciality) 2. I have examined ______ (state practitioner's name and identity number) on _____ (date) It is my professional opinion that she/he suffers from the following medical condition / physical / learning disability:

DSM 5	TR Diagnosis/ ICD 11 Code		
4.	Permanent or temporary disability?		
5.	It is my professional opinion the patient experiences the following limitations as a result of		
	their disability/impairment/medical condition/s:		
6.	Further detail about the patient's diagnosis, the history of the condition and the duration of its effects are clearly documented in the attached reports.		
7.	In my professional opinion I would make the following recommendations:		
8.	Please provide comment on the prognosis and treatment plan as well		

I confirm that the above and the attached documentation are a true and correct reflection of the			
condition of the patient		_ (state practitioner's name)	
		PRACTITIONER'S STAMP	
	(Name)		
	_(Signature)		
	(Date)		

Please note the following:

- 1. The document or attached report should be written within the past 2 years.
- 2. The document or attached report must be printed on the practitioner's official letterhead