

MEDICALLY RESTRICTED ONCE COMPLETE

REVIEW OF INJURY AWARD QUESTIONNAIRE

| PERSONAL DETAILS | |
|------------------|--|
| Full Name | |
| Address | |
| Phone Number | |
| E-mail address | |
| Date of Birth | |
| Date Left Force | |

| HEALTH |
|--|
| Describe your current medical conditions and any changes since your last review by the Force Selected Medical Practitioner. <i>Please include details of any referrals to specialists and treatments received plus current medication.</i> |
| |

| WORK |
|---|
| Describe the changes in your work since your last review by the Force Selected Medical Practitioner. <i>Please include the type of work undertaken and your salary.</i> |
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STATE BENEFITS & OTHER INCOME

Please list and provide evidence of the current State Benefits and any other earned income received.

EDUCATION/TRAINING

Describe any Education or Training you have received since your last review by the Force Selected Medical Practitioner.

ADDITIONAL INFORMATION

Please include here any further information which you consider relevant for a review.

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DECLARATION

I declare that the information I have provided is accurate and correct to the best of my knowledge. I confirm that I have not knowingly withheld any relevant information.

Signed:

Dated:

AND FINALLY, PLEASE NOTE THAT;

- 1) Failure to provide full information relevant to the review may result in the Selected Medical Practitioner either making a determination based upon the facts and information available or declining to make a determination.
- 2) Once completed, please return, together with any additional documentation, to the Force Selected Medical Practitioner at the address given below marked 'Strictly Private & Confidential'.

SMP Address;

CONTINUATION SHEET *(for your use as required)*