**Confidential Medical Report for Occupational Health Service Provider**

**To Accompany a Doctor to Doctor Report**

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| **TO BE COMPLETED BY TEACHER *Please note that incomplete applications may give rise to a delay*** |
| **TEACHER’S FULL NAME:**(*Block Capitals)* |  |
| **Address:** |  |
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|  |
| **Phone Number:** |  | **Date of Birth:** |  |
| **Mobile Phone Number:** |  | **PPSN:** |  |
| **School/Centre Name and Address:** |  |
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|  |
| **Name of ETB:** |  |
| **School Roll Number:** |  | **School/Centre Type (e.g. Second level/Further Ed):** |  |
| **Note to Doctor**I am applying for pension and lump sum from the ETB Teachers’ Superannuation Scheme, on the grounds of permanent medical infirmity which causes me to be permanently incapable of teaching. If awarded ill health retirement I will be deemed to have retired from my teaching post and I accept that I will be prohibited from teaching thereafter in any capacity in an educational establishment funded by the State. The first step in this process is for you as my current treating doctor to complete and provide aconfidential medical report to the Occupation Health Service Provider detailed below. Please attach a “Doctor to Doctor” report to this form detailing your diagnosis, treatment and prognosis and forward to the address below**.** The “Doctor to Doctor” report to include responses to the following questions: * What has been the state of the patient’s health during the last five years?
* What is the nature of the physical or psychiatric condition(s) from which the patient is now suffering?
* Treatment options which have been undertaken (e.g. medication/ surgical treatment/ counselling/ psychotherapy etc)?
* Have all reasonable treatment options been explored?
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| **TO BE COMPLETED BY CURRENT TREATING DOCTOR** |
| 1. Are you the teacher’s current treating doctor?
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| 1. How long has this teacher attended you as a patient?
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| 1. When has this teacher last attended you as a patient?
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| 1. If the teacher has been attending a specialist physician, you may include a report from that specialist.
 | ***Attending specialist******Yes/No*** | ***Report attached*** ***Yes/No*** |
| **DOCTORS NAME:** *Block Capitals* |  |
| **DOCTORS SIGNATURE:** |  |
| **Doctor Stamp:** |  | **Date:** |  |
| Thank you for completing this form and providing medical report. Your opinion is appreciated. | Please tick that you have attached report as requested |  |