



Mining Industry Pension Fund
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MEDICAL REPORT

(PLEASE PRINT AND USE BLOCK CAPITALS)

Dear Medical Practitioner

You are being required to fill in this form for the purpose of ill-health/disability early retirement claim.

(INFORMATION SUPPLIED WILL BE TREATED IN STRICT CONFIDENCE)

1 FULL NAME OF PATIENT.....

MIPF R/S NO:..... MINE NO:.....
(Obtainable from patient)

NATIONAL REGISTRATION NO:.....

2 DATE OF FIRST EXAMINATION:.....

DATES OF SUBSEQUENT EXAMINATIONS:.....

3 NATURE OF DUTIES/ OCCUPATION:.....

4 DIAGNOSIS, CAUSE & NATURE OF ILL-HEALTH/DISABILITY (Please state if work related or not)

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- (a) Is condition permanent ? YES/NO
- (b) Is he/she capable of continuing with current duties ? YES/NO
- (c) Is he/she capable of performing other duties ? YES/NO

5 ANY ADDITIONAL INFORMATION

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FULL NAME OF MEDICAL PRACTITIONER.....

MEDICAL REGISTRATION NUMBER OFFICIAL STAMP and SIGNATURE

ADDRESS:
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TELEPHONE NO:..... DATE:...../...../.....

PLEASE RETURN COMPLETED FORM TO THE BENEFITS MANAGER.