FIJI PUBLIC SERVICE ASSOCIATION

Local Medical Claim Form (Specialized Surgical)

A.

1. Name of Member:……
2. EDP/EMPLY No…… 3. Post Held…….
4. Ministry/Dept…….. 5. Station ……
6. Date of Birth…… 7. Gender ……
8. Postal Address ……
9. Residential Address ……..
10. Telephone: Office …….. Residence ……..
11. Date Joined Service ……..

B.

1. Place of treatment (Hospital) ……..
2. Date of surgical treatment ……
3. Has assistance been sought from other sources? Yes/No ……..
4. If yes, how much?.....

I declare that I have maintained continuous membership of the FPSA over the past 13 months and the information given is true and complete.

..... …….

Date Signature

Document Required

1. Doctors Medial Report (Referral)
2. Consultant/Specialist Medical Report.