AAMI Driver Protection Cover

Medical Certificate – This form is to be completed by a Medical Practitioner

Claimant's full name _____ Claimant's Date of Birth / /

Claimant's address _____

Suburb _____ State _____ Postcode _____

Date of accident / / Date of initial consultation / /

1. Was the accident the sole or substantial contributing cause of the injury? Yes ☐ No ☐

Please give details of any other contributing causes of the injury

_____

2. Was the injury directly or indirectly caused by, or due to psychological or psychiatric causes, sickness or disease? Yes ☐ No ☐

If yes, please give details

_____

Did the patient sustain any of the below injuries in the subject accident?				
Area of body	**Injury sustained**	**Tick all that apply**		**Additional information if applicable**
Head	Fractured Skull			
	Total loss of power of speech			
	Total loss of hearing			
Trunk	Laceration of internal organs	Liver		
		Kidney		
		Spleen		
		Lung		
	Fractured bones	> 4 Ribs		
		Pelvis		
		Sternum		
Spine	Fractured vertebrae			
Arms and Legs	Fractured bones (excluding hands or feet)			
Other Injuries	Full thickness burns (to at least 10% of the body but not greater than 30% of the body)			
	Any other injuries sustained			

Medical Practitioner Information

Full name

Provider number

Practice/hospital name and address

Suburb

State

Postcode

Telephone number

Professional qualification

I declare that I am a Registered Medical Practitioner and to the best of my knowledge the information provided here is true and correct.

Signature

Date / /

Please email this certificate including any other relevant documents to driverprotectioncoverSA@aami.com.au or by mail to AAMI, GPO Box 471 Adelaide SA 5001