NI 34A

THE NATIONAL INSURANCE BOARD
CHILD ALLOWANCE - MEDICAL REPORT

(PLEASE USE BLOCK/CAPITALS)

(FOR OFFICIAL USE)
CLAIM NO:
SERVICE CENTRE CODE:

SECTION "A" - TO BE COMPLETED BY APPLICANT

PARTICULARS OF DECEASED:

1. DECEASED NAME: SURNAME / OTHER NAME(S)
2. DATE OF DEATH: YYYY MM DD
3. NATIONAL INSURANCE NO.:

PARTICULARS OF APPLICANT:

1. APPLICANT'S NAME: SURNAME / OTHER NAME(S)

I declare that to the best of my knowledge and belief the information given by me is true and correct and I am aware that if there is any statement in this declaration which is false in fact or which I know or believe to be false or do not believe to be true, I am liable on summary conviction to a fine of three thousand dollars ($3,000.00) and to imprisonment for two years in accordance with Sect 33, NI Act Chap 32:01.

SIGNATURE OR MARK OF APPLICANT

DATE: YYYY MM DD

PARTICULARS OF WITNESS TO MARK (Where Claimant Cannot Sign)

NAME: SURNAME / OTHER NAME(S)

ADDRESS: (STREET)

(CITY/DISTRICT/COUNTY)

VALID IDENTIFICATION: (Tick appropriate box)
- PASSPORT
- DRIVER'S PERMIT
- ELECTORAL I.D.

OCCUPATION:

NUMBER:

SIGNATURE OF WITNESS TO MARK

DATE: YYYY MM DD

SECTION "B" - MEDICAL REPORT *(To be completed by a Registered Medical Practitioner)*

1. CHILD'S NAME: SURNAME / OTHER NAME(S)
2. HOME ADDRESS: (STREET) (CITY/DISTRICT/COUNTY)
3. DATE OF BIRTH OF CHILD: YYYY MM DD
4. (a) Is child physically disabled? YES NO

   (b) Is child mentally disabled? YES NO
5. If the answer to question 4 (a) or (b) is "Yes"

   (a) Please give a full clinical description of the disability.

   (b) Please state the date on which the disability was diagnosed. DATE: YYYY MM DD

01/2008

SECTION "B" - MEDICAL REPORT *CONT'D (To be completed by a Registered Medical Practitioner)*

6. How long have you been treating this patient? ____________________ Days/Months/Years.
(Words and Figures)

PARTICULARS OF MEDICAL PRACTITIONER:

NAME OF MEDICAL PRACTITIONER:
SURNAME
OTHER NAME(S)

OFFICE ADDRESS:
(STREET)
(CITY/DISTRICT/COUNTY)

REGISTRATION NUMBER OF MEDICAL PRACTITIONER:

TELEPHONE NUMBER: --

I declare that to the best of my knowledge and belief the information given by me is true and correct and I am aware that if there is any statement in this declaration which is false in fact or which I know or believe to be false or do not believe to be true, I am liable on summary conviction to a fine of three thousand dollars ($3,000.00) and to imprisonment for two years in accordance with Sect 33, NI Act Chap 32:01.

MEDICAL PRACTITIONER'S STAMP

SIGNATURE OF MEDICAL PRACTITIONER

DATE: YYYY MM DD

SECTION "C" - FOR OFFICIAL USE

APPLICATION RECEIVED BY:

NAME:
SURNAME
OTHER NAME(S)

SERVICE CENTRE STAMP

SIGNATURE OF SERVICE CENTRE STAFF

DATE: YYYY MM DD