

**REPORT FORM
 LOSS OF HEALTH
 CERTIFICATE**
 Operatør /Boring / Forpleining

Please use capital letters.

Page 1 of 2

INFORMATION REGARDING AFFECTED PERSON. NB! All sections of the form must be filled in.			
Name:		Personal identification number:	
Address:		Postcode:	City:
Telephone daytime:			
Offshore employee since: DD.MM.YYYY			
Position:		Location:	Permanent employee: <input type="checkbox"/> Yes <input type="checkbox"/> No
Work percentage: %	First day of employment: DD.MM.YYYY		Last day: DD.MM.YYYY
Trade organisation: <input type="checkbox"/> Industri Energi <input type="checkbox"/> Lederne <input type="checkbox"/> SAFE <input type="checkbox"/> Other			
Which wage agreement are you included in?			
Bank account number:			

Company:		Telephone no.:	
Address:			
Postcode:	City:		

Treating doctor:		Address:	
Specialist/hospital:		Address:	
Health certificate confiscated by (doctor's name and address)			
Confiscation date:		Diagnosis:	
The affected person is currently: <input type="checkbox"/> working full-time <input type="checkbox"/> On partial sickleave <input type="checkbox"/> on full sickleave			
Most recent sickleave, date:			
Which social security office do you belong to?			
Will you be appealing against the decision regarding incapability? <input type="checkbox"/> Yes <input type="checkbox"/> No			

