

SOCIAL SECURITY (MEDICAL CERTIFICATES) REGULATIONS, 2010

[22nd November 2010]

SI. 81 of 2010

ARRANGEMENT OF REGULATIONS

1. Citation
 2. Interpretation
 3. Claim for sickness or injury benefit
 4. Date of issue of medical certificate
 5. Period covered by medical certificate
 6. Final certificate
 7. Medical practitioner must issue certificate
 8. Medical board must issue report
- Schedule – Forms

Social Security (Medical Certificates) Regulations, 2010

1. These Regulations may be cited as the Social Security (Medical Certificates) Regulations, 2010.

2. In these Regulations —

“medical certificate” means the relevant medical certificate in the form set out in the Schedule;

“medical practitioner” includes —

- (a) in relation to a certificate made out and issued in Mahe, a midwife registered under the Nurses and Midwives Act, 1985; or
- (b) in relation to a certificate made out and issued in any place in Seychelles other than Mahe, a midwife or nurse registered under the Nurses and Midwives Act, 1985; or
- (c) in the absence of a medical practitioner registered in Seychelles under the written law relating to the registration of medical practitioners in Seychelles, midwife or nurse, the manager of the relevant island or any person authorised by the Minister to administer medical treatment and to issue certificates for the purposes of these Regulations;

“Social Security Section” means the public body for the time being responsible for social security.

3. (1) A person making a claim for sickness or injury benefit shall furnish the Director with evidence of that person's incapacity to work in respect of the days for which the claim is made in the form of a medical certificate made out as in Form 1 of the Schedule.

(2) A woman making a claim for maternity benefit shall furnish the Director with evidence of her confinement or expected confinement for birth in the form of a medical certificate made out as in Form 2 or Form 3, as the case may be, of the Schedule.

(3) A person making a claim for invalidity or disablement benefit shall furnish the Director with evidence of the degree of his or her invalidity or disablement in respect of the period for which the claim is made in the form of a report given by the Medical Board and made out as in Form 4 of the Schedule.

(4) Subject to subregulation (5), a person making a claim for survivor's benefit shall furnish the Director with evidence of death of that person's spouse, being a person covered, in the form of a death certificate made out as in Form 5 of the Schedule.

(5) Where the person referred to in subregulation (4) makes a claim for widower's pension, the person shall, in addition to the certificate referred to in subregulation (4), furnish the Director with a certificate referred to in subregulation (3) for the period for which the claim is made.

(6) For the purposes of this regulation "spouse" has the same meaning as in the Social Security (Benefits) Regulations 2010.

4. A medical practitioner shall make out and issue a medical certificate on the date of the examination on which the certificate is based and he or she shall not thereafter issue any other medical certificate for the purpose of these Regulations based on the same examination, other than a duplicate of the first- mentioned certificate in which case the duplicate shall be clearly marked with the word "duplicate".

5. A medical certificate shall specify the number of days, which shall include the day on which the examination is carried out, for which the person named in the certificate is incapacitated for work:

Provided that any period of incapacity specified in the certificate shall not exceed 28 continuous days, including the day of examination, unless on the day of the examination the person named in the certificate had been incapacitated for a continuous period of 28 days in which case the period of incapacity in the certificate shall not exceed 91 days.

6. Before resuming work a person who has been in receipt of, or has claimed, sickness or injury benefit shall furnish the Director with a certificate specifying the date on which, in the opinion of the medical practitioner, the person named in the certificate will become fit to resume work.

7. A medical practitioner shall, if requested by a patient—

(a) after examining the patient; and

(b) where the medical practitioner is of the opinion that the patient —

(i) is likely to remain incapacitated for work for any period in excess of one day;

(ii) in the case of a woman, is expected to be or has been confined for childbirth; or

(iii) is likely to be fit to resume work after a period of incapacity;

issue the patient with the relevant certificate set out in the Schedule within 24 hours after examining the patient.

8. (1) The Medical Board shall examine —

(a) a person who has been in receipt of sickness benefit for a period of 130 continuous working days and who the medical practitioner has certified is likely to remain incapacitated for work beyond the 130 days;

(b) a person who is over the age of 15 years and to whom section 12 applies;

- (c) a person referred to in paragraph (a) or paragraph (b) who has re-submitted a claim, after having had the person's claim disallowed in the first instance, on the ground that the person's condition has deteriorated since the date of the last claim;
- (d) a person referred to in paragraph (a) or paragraph
- (b) who has been granted and is in receipt of a benefit every six months, or such longer period as the Medical Board considers necessary, after the date of his last examination by the Medical Board;
- (e) a person who is claiming widower's pension; and
- (f) any person who has been referred to the Medical Board by the Director, and shall issue a report in respect of that person as in Form 4 of the Schedule.

(2) the Medical Board shall, each time it makes out a report under this regulation, send a full copy of the report to the Director.

SCHEDULE

(Regulation 2)

FORM 1

MEDICAL CERTIFICATE

Clinic: _____ NATIONAL IDENTITY NUMBER

Date: _____

Name: _____

□ □ □ □ □ □ □ □ □ □

Age: _____ Sex: _____

Occupation: _____

Employer: _____

Diagnosis: _____

Fit / Unfit: _____

Returned to work on: _____ Returned to clinic on: _____

Admitted to (Ward): _____

Doctor's Name: _____ Signature: _____

Other Comments: _____

Serial Number: _____

MEDICAL CERTIFICATE

Date: _____

□ □ □ □ □ □ □ □ □ □ □ □ □

Mr / Mrs/ Miss:

Age: _____

He / She should return to work on:

(Enter day and date)

He / She should report again on:

He / She has been admitted on _____

Other Comments:

Name _____ Signature: _____

Serial Number:

1. The certificate shall be made out in ink and completed in full and signed by the medical practitioner who carried out the examination.
2. It shall give —
 - (a) the date of the examination on which the certificate is based;
 - (b) an indication of the disease, disablement or injury by which the claimant is, in the medical practitioner's opinion, rendered incapable of work;
 - (c) the period for which, in the opinion of the medical practitioner, the claimant will be incapable of work;
 - (d) where the certificate is given by a medical practitioner other than a doctor of medicine, there shall also be given a concise statement of the symptoms noted at the time of the examination, and shall bear the signature of the certifying medical practitioner written after there have been entered on the certificate the details listed above; such certificate shall, in due course, be countersigned by a Government Medical Officer.

CERTIFICATE OF CONFINEMENT

Full Name

□ □ □ □ □ □ □ □ □ □ □ □

NATIONAL IDENTITY NUMBER _____ Date of Birth / /

I certify that _____ was confined on _____

(name)

(date)

at _____ a.m./p.m. at Hospital /

(time)

(other

address)

Date of Examination / / Form No.

The confinement resulted in a live / still birth / multiple birth*/ of

Signature Doctor / Midwife*

* delete inappropriate items

Notes:

1. The certificate shall be made out in ink and completed in full and signed by the medical practitioner attending the woman.
2. It shall state the date of the examination on which the certificate is based and the date on which the certificate is given.

FORM 3

CERTIFICATE OF EXPECTED CONFINEMENT

Full Name

☐☐☐ ☐☐☐☐☐☐☐☐☐

NATIONAL IDENTITY NUMBER

Date of Birth..... / /

I certify that in my opinion will be
confined

(name)

(date)

during the week commencing / /

Date of Examination / /

The confinement resulted in a live / still birth / multiple birth*/ of

Signature Doctor / Midwife*

* delete inappropriate items

Notes:

1. The certificate shall be made out in ink and completed in full and signed by the medical practitioner attending the woman.
 2. It shall state the date of the examination on which the certificate is based and the date on which the certificate is given.
-

FORM 4
REPORT BY THE MEDICAL BOARD
PART 1

□ □ □ □ □ □ □ □ □ □
NATIONAL IDENTITY NUMBER

1. Full Name of Claimant: _____
2. Date of Birth: _____
3. Name of Doctors on the Board

and their Speciality:

CHAIRMAN

..... ..

MEMBER

..... ..

MEMBER

4. Date of Examination:
5. Precise statement of the disease, injury or disablement by which the claimant is,
in the opinion of the board, rendered incapable or partially incapable of work :

.....
.....
.....
.....

6. State date or approximate date from which the condition has existed or indicate
the development :

.....
.....
.....
.....

7. Possible date for next Board examination required. No need to refer
again.

Refer inmonths.

8. Has the claimant been examined by the Medical Board before? YES / NO

YES / NO

If yes, please state :

Date

Result

and % incapacity

PART II

(This part may be copied to the claimant)

1. In the opinion of the Medical Board which examined Mr / Mrs / Miss
onthe claimant is incapacitated to the
extent of%
2. He / She should be capable of working
hours a week as a
(state type of work that the applicant is capable of).
3. Date of next Medical Board examination if required

Signed:

CHAIRMAN

Date:

FORM 5

CERTIFICATE OF DEATH

I

(Name of Medical Practitioner)

an authorised Medical Practitioner hereby certify that

* I attended

* did not attend

.....

(Name of deceased)

of aged

who died, I am informed, at

on

The causes of death were, to the best of my knowledge, as follows:

CAUSES OF DEATH		Approximate interval between onset and death
I		
Disease or condition directly leading to death *	(a)	due to, or as a
consequence of		
Antecedent cause morbid	(b)	due to, or as a
conditions, if any, giving rise		
consequence of		

to the above cause, stating
the underlying condition last

(c)

II

Other significant conditions
contributing to death, but
not related to the disease or
condition causing it

.....

.....

* This does not mean the mode of
dying, e.g. heart failure, asthenia,
etc. It means the disease, injury or
complication causing death

* Body seen } after death
performed

* Case reported to Coroner * PM

* Body not seen }

* Case not reported to Coroner

* PM not performed

Signed :

Date :

* delete where inapplicable

Notes :

1. The certificate shall be made out in ink and completed in full and signed by the medical practitioner issuing the certificate.
2. It shall give a concise statement of the cause of death, the date and approximate time of death and the date on which the certificate is given.

(Reverse of Certificate of Death)

To be completed by next of kin / person responsible for funeral arrangements *

□ □ □ □ □ □ □ □ □ □

NATIONAL IDENTITY NUMBER

Full Name of deceased:

I of

(full name)

(address)

wish to claim a survivor's benefit as follows —

Funeral Benefit

Widow's Benefit

Widower's Pension

Widowed Mother's Pension

Widow's Pension

Please tick the benefits you wish to claim and a form will be set to you.