Motor Accident Medical Report (MAMR)

As prescribed under section 102(2)(b) of the *Road Transport (Third-Party Insurance) Act 2008*
For Compulsory Third-Party (CTP) Insurance Claims in the Australian Capital Territory (ACT).

Instructions

- This Motor Accident Notification Form (MANF) is the first of three (3) forms to be filled out by the injured party (the Claimant) to a motor vehicle accident:

  1. Motor Accident Notification Form (MANF)
  2. **Motor Accident Medical Report (MAMR)**
  3. Notice of Claim and Additional Information Forms (NOCAIF)

- If you are a Claimant, you should fill out this form after completing the Motor Accident Notification Form (MANF) if you are seeking early payment of medical expenses.

- In filling out this form, you must provide all documents that will assist the Insurer in processing your claim; this includes copies of receipts evidencing medical expenses.

- In providing information about pre-existing injuries exacerbated by the motor vehicle accident, you should also provide information about prior injuries, illnesses or disabilities which were not exacerbated by the motor vehicle accident. If you do not provide this information, it can affect your entitlement to claim damages and economic loss.

This form is Approved Form AF2008-126, approved on 12 September 2008 by Tom McDonald, delegate of the chief executive, under section 276 of the *Road Transport (Third-Party Insurance) Act 2008*.

Motor Accident Medical Report

As prescribed under section 102(b) of the *Road Transport (Third-Party Insurance) Act 2008*
For Compulsory Third-Party (CTP) Insurance Claims in the Australian Capital Territory (ACT).
This Motor Accident Medical Report is to be completed by the Claimant and a Medical Practitioner.
For information on the ACT Compulsory Third-Party Scheme visit the
ACT Department of Treasury web site at:
www.treasury.act.gov.au/compulsorytpi/index.shtml

1. Claimant's Information—to be completed by the claimant

Claimant's Surname/Family Name	Given Names	Date of Birth
		/ /

What are your injuries from the accident? (List all injuries – attach a list of further injuries if you run out of space.)

How do your injuries affect you now? (For example: pain in neck on bending, etc.)

Did you see a doctor (general practitioner) after the accident?

No ☐
Yes ☐

If yes, state doctor's name and address and date of first consultation since the accident

Postcode
/ /

List all other medical practitioners, surgeons, physiotherapists, psychologists and specialists who have medically treated you for your injuries since the accident.

Were you admitted to hospital?

No ☐
Yes ☐

If yes, please state the date of admission and date of discharge.

Admission: / /
Discharge: / /

What treatment or rehabilitation are you receiving or planning to undertake? Please give details.

Have you previously sustained an injury [illness or disability*] to the same body parts or area that have been made worse because of this accident? [*includes significant disability]

No ☐
Yes ☐

If yes, please give details.

I declare that, to the best of my knowledge, the information provided here is true and correct.

Signature		Date
		/ /

2. Medical Information—to be completed by a medical practitioner

Date of Accident	Date of Initial Examination		
/ /	/ /	Are the injuries/conditions consistent with the circumstances of the motor accident described to you?	☐ Yes ☐ No

Description of Injury / Diagnosis

Clinical Findings (symptoms, results of any investigations and details of treatment/rehabilitation to date)

How long have you known this patient?

Has the patient had a similar condition?

Did the patient require an ambulance?	Did the patient attend hospital?	If admitted to hospital, was it more than 1 day?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Name of Hospital

Date of first attendance at hospital

/ /

Will further treatment or therapy be required?

☐ Yes ☐ No

Date patient was discharged from hospital

/ /

Details of Treatment, Medication and / or Therapy Necessary or Likely

Referred to:	Type	Name of Person	Phone Number or Contact Details
☐ Specialist			
☐ Therapist			
☐ Other			

Describe the patient's fitness for work	Date of Next Medical Review
☐ Fit to resume normal duties Date: / /	/ /
☐ Certified fit for alternative duties. Date from: / / to / /	
☐ Certified unfit for work. Date from: / / to / /	

3. Medical Practitioner's Information

Name (please print)		Provider Number
		/

Practice Name and Address/Hospital Name

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
		/ /

Protection of Privacy

- The information collected by this Motor Accident Medical Report, is collected in accordance with the *Road Transport (Third-Party Insurance) Act 2008* and *Road Transport (Third-Party Insurance) Regulation 2008* (*Regulation*).
- The information is collected so as to encourage the speedy resolution of personal injury claims resulting from motor vehicle accidents, and to help the administration of the statutory insurance scheme and the detection of fraud.
- The information collected by this Motor Accident Medical Report may be disclosed in accordance with the *Road Transport (Third-Party Insurance) Act 2008* and *Road Transport (Third-Party Insurance) Regulation 2008* (*Regulation*) to such bodies as, the CTP regulator, the Nominal Defendant, and other insurers or parties involved in the assessment of your claim, such as those indicated below.
- Failure to provide all or part of the information may delay or prevent the assessment of your claim.
- You are able to gain access to personal information held as provided by the *Privacy Act 1988* (Cth), or if the information is held by the Australian Capital Territory Government, you are able to gain access to the information as provided by the road transport legislation.

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