**Form 4: Request for Review of Medical Assessment**



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| **Review criteria**You must lodge this Request for Review of Medical Assessment form with [Name of Service Provider] and your agency within 21 calendar days of the date of the final medical assessment report; and your request must meet (a) and/or (b) listed in Part B of this form. NOTE: In order for [Name of Service Provider] to assess your eligibility for review you must provide the necessary information to support your claim in Part B of this form.**Review process**[Name of Service Provider] will assess your request against the review criteria. If your request meets the review criteria you and your agency will be advised of the review date. Your request, and all relevant supporting documents, will then be provided to the independent Review Panel to make their determination. The Review Panel Chairperson will send the panel’s determination to you and your agency approximately two weeks after the review date. |

## Part A : Employee details

**Last name** **Given name(s)** **Date of birth**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| (Insert here) |  | (Insert here) |  | (Insert here) |

**Former name (if applicable)** **Gender** **Employee number**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| (Insert here) |  |  [ ]  **Male** [ ]  **Female** [ ]  **Other** |  | (Insert here) |

**Work address** **Work phone** **Work email**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| (Insert here) |  | (Insert here) |  | (Insert here) |

**Home address** **Home phone** **Home email**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| (Insert here) |  | (Insert here) |  | (Insert here) |

**Date of medical assessment** **Mobile phone** **Confirmation SMS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| (Insert here) |  | (Insert here) |  |  [ ]  **Yes**  [ ]  **No** |

## Part B : Basis for review request

**(Place a ☒ against the applicable statement/s and provide details that support your claim. Attach a separate page if you need more space)**

**[ ]  a. Relevant information about my medical condition was available and offered but not considered at the time of my assessment.**

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| (Insert detail and supporting evidence here) |

**[ ]  b. Reasons for the nominated medical assessor’s recommendation were not consistent with the available information.**

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| --- |
| (Insert detail and supporting evidence here) |

* I authorise the release of my medical assessment records, held by [name of Service Provider], to the independent Review Panel.
* I understand that I may be required to undergo a further medical assessment by a medical specialist if the independent Review Panel determines a file review alone is inadequate, and authorise the release of this medical information to relevant individuals in my Agency and medical specialist (if required).

**Name** **Signature**  **Date**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| (Insert here) |  |       |  | (Insert here) |