Injury on Duty Grant / Pension

SOCIAL SECURITY

38, Ordnance Street, Valletta, VLT 1021
E-mail: social.security@gov.mt
Website: www.socialsecurity.gov.mt
Freephone 153

** Indicates mandatory information*

Report of Medical Specialist

The person named below:

Identity Card Number: * _____

Name: * _____ Surname: * _____

Address: * _____

_____

Is hereby certified to suffer from a percentage disablement of _____% because of an Injury or Disease suffered during his/her employment or self-occupation.

A detailed description of the diagnosis and opinion regarding the current medical condition is required to be filled-in in the space below. Additional pages may be added and endorsed if the supplied space is deemed as insufficient for the description of claimant's medical condition.

_____

_____

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_____ _____

Signature of Medical Specialist Date

Rubber Stamp