

Injury on Duty Grant / Pension



38, Ordinance Street, Valletta VLT 1021
Contact Us: contactdss.gov.mt
Website: socialsecurity.gov.mt
Sevizz.gov Freephone 153 (Ext. 11)

** 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.

Signature of Medical Specialist

Date

Rubber Stamp