Te Tira Ahu Ika A Whiro
VETERANS' AFFAIRS
New Zealand

Treatment and Rehabilitation

Veteran's Personal Details

1	**Veterans' Affairs number (if known)**									
2	**Title**	Rank		Mr		Mrs		Ms		Other
3	**Last name**									
4	**First name/s**									
5	**Other name/s known as**									
6	**Date of birth**	/ /								

For **new** claimants **only**— please attach a certified copy of your full birth certificate; current passport, driver licence or firearms licence for identification purposes.

7 Residential Address

Country (if not New Zealand)	Post Code

8 Postal Address (if different from residential address)

Country (if not New Zealand)	Post Code

9 Other Contact Details

Home Phone	Work Phone
Mobile Number	E-mail Address

Employment History (excluding service)

10 Details of Employment

Please provide details of your employment before **and** after service in the New Zealand Defence Force (NZDF)

		Commenced		Ended	
Employer	Nature of Work	Month	Year	Month	Year

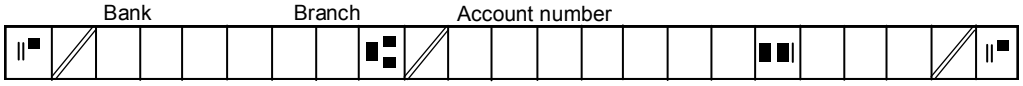
Only complete this if Veterans' Affairs does **NOT** already have a current bank account

11 Bank Details

This will be the account Veterans' Affairs will make any payments to

Name of bank	Branch
Account Name	

Write your bank account number below and attach an original or certified copy of your bank



Service History

12 Qualifying Service

Refer to the list of qualifying service found on our website

Did you serve with the New Zealand Armed Forces? ☐ No ☐ Yes

If yes, what period did you serve and what is your service number?

Your Medical Information

13 Accidents and Injuries

Have you suffered an injury from an accident for which you have applied for compensation?

☐ No ☐ Yes If yes, please provide details of injury, date of accident, organisation/s.

Details of injury and organisation/s	Date of Claim Day	Month	Year

Have you suffered an injury from an accident for which you have not applied for compensation?

☐ No ☐ Yes If yes, please provide details of injury, date of accident.

Details of injury	Date of Claim Day	Month	Year

14 Health Practitioner (other than your current Medical Practitioner, if applicable)

Please provide the name and contact details of any other health practitioner providing treatment or rehabilitation to you. Continue on a separate sheet if necessary. Your Medical Practitioner may be able to assist with these details if you are unsure.

Name and Profession	
Practice Name	
Address	
Phone	

Medical Certificate Part 1

15 Details of the injury or illness/s you are requesting treatment or rehabilitation for

VETERAN to complete	MEDICAL PRACTITIONER to complete
Please provide the name of the injury or illness, if known. Describe as fully as you can the symptoms that make you notice the injury or illness (e.g. pain in lower back, shortness of breath, loss of range of movement in left arm). **Write each injury or illness separately.**	For each claimed injury or illness provide a detailed **diagnosis**; indicate whether **stable** or **not stable** and attach copies of any records, specialist reports and investigations.

A **Injury or illness:**	**Medical Diagnosis and causation of injury or illness:**
Symptoms:	
	Basis for Diagnosis:
When did the injury / illness occur?	
	Past treatment:
Describe how your injury or illness impacts on your life? Continue on further page if needed	
	Current treatment and impact on daily living:
How do you believe this injury or illness relates to your service? Continue on further page if needed	
	Date of clinical onset:

Continued on the next page

VETERAN to complete	MEDICAL PRACTITIONER to complete
Please provide the name of the injury or illness, if known. Describe as fully as you can the symptoms that make you notice the injury or illness (e.g. pain in lower back, shortness of breath, loss of range of movement in left arm). **Write each injury or illness separately.**	For each claimed injury or illness provide a detailed **diagnosis**; indicate whether **stable** or **not stable** and attach copies of any records, specialist reports and investigations.

B	Injury or illness:	Medical Diagnosis and causation of injury or illness:
	Symptoms:	
		Basis for Diagnosis:
	When did the injury / illness occur?	
		Past treatment:
	Describe how your injury or illness impacts on your life? Continue on further page if needed	
		Current treatment and impact on daily living:
	How do you believe this injury or illness relates to your service? Continue on further page if needed	
		Date of clinical onset:

Send your completed application to:

Veterans' Affairs
PO Box 5146
WELLINGTON 6140

Guidance Notes for Medical Practitioner

Treatment and rehabilitation is available under the Veterans' Support Act 2014 for a service-related injury or illness.

Completing the Medical Certificate:

- Complete the 'Medical Practitioner' portions for each injury or illness being claimed.
- Attach your invoice and any supporting documentation such as medical reports, blood test results etc.
- Return the completed form, invoice and supporting documentation to the veteran.

Veterans' Affairs will meet the cost of the consultation and completion of this medical certificate upon receipt of the completed application and your invoice. Please attach your invoice to this form.

Medical Certificate Part 2

MEDICAL PRACTITIONER to complete

16 Veteran's Name

17 Veteran's NHI Number

18 Examination Date **Prior to today when did you last examine the veteran?** / /

19 Terminal Injury or illness

Does the veteran suffer from an advanced progressive disease likely to cause death within 12 months?

☐ No ☐ Yes If yes, please state the injury or illness below

20 Enrolment History **Is the veteran enrolled with your practice?** ☐ No ☐ Yes

If yes, how long have they been enrolled with you? ☐ Years ☐ Months

If no, provide the name and contact details of their usual medical practitioner (if known)

Name of Practitioner
Practice Name

21 Medical Practitioner Identity

HPI No. ☐☐☐☐☐☐ **Medical Council Registration No.**

Name
Practice Stamp (or address and telephone)
Medical Practitioner Signature / /

Privacy Statement

You can read our full privacy statement on our website

Your personal information is managed in accordance with the privacy statement on our website:

- www.va.mil.nz/privacy

If you would like a copy of this posted to you please contact us:

- 0800 483 8372 from New Zealand
- +64 4 495 2070 outside New Zealand

Signature

This form must be signed either by the claimant or a person with the authority to act on the behalf of the claimant if they are unable to do so.

If the claimant didn't sign the form, **include one** of the following forms of evidence:

- Power of Attorney or Enduring power of Attorney (in relation to Property)
- Certificate of Administration (from the Public Trustee)

I acknowledge that:

- the information I have given in this claim form is true and correct
- Veterans' Affairs may obtain further information to assess and decide on my claim
- I have read and understood the Privacy Statement for Forms on www.va.mil.nz/privacy
- I authorize the collection and disclosure of health, clinical, or other personal information by or to Veterans' Affairs, held by any doctor or health practitioner or named agencies, or service providers, or contractors for the purposes set out in the privacy statement; for the purposes of assessment of this claim; administration of any resulting entitlement; and the provision of any services, treatment or rehabilitation under the Veteran's Support Act 2014.

Signature | Please sign

Claimant or authorised person

Claimant or authorised person name

Claimant or authorised person signature

D D / M M / Y Y Y Y

Helper | Complete this section if you've helped the claimant to complete this form.

Helper name

Helper's relationship to claimant