Treatment and Rehabilitation

APPLICATION FORM

Te Tira Ahu Ika A Whiro
VETERANS' AFFAIRS
New Zealand

Veteran's personal details

1 Veterans' Affairs number (if known)

☐☐☐☐☐☐☐☐☐

2 What is your title?

Rank ☐ ☐ Mr ☐ Mrs ☐ Ms ☐ Miss Other ☐

3 What is your full name?

First name

Middle names

Family name

Preferred name

4 What is your date of birth?

D D / M M / Y Y Y Y

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

5 Where do you live?

Street address

Suburb

City Postcode

Country

6 If your postal address is different to where you live, enter details below.

Street address

Suburb

City Postcode

Country

Your personal details *continued …*

7 What are your contact details?

Email

We will contact you to verify this address

Home phone

Mobile phone

Work phone

8 What bank account do you want payments to be made to?

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

Name of the account

You must attach **one** of the following

- ☐ A bank account statement, printout, or letter issued within the last six months that includes the bank's letterhead and stamp, **account holder's name and the account number**, or
- ☐ A screenshot from a banking app or website that displays **all** of the following:
  - The account holder's full name
  - The name or logo of the bank, and
  - The bank account number.

Employment history (excluding service)

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

Employer	Nature of Work	Approx. start MM/YYYY	Approx. end MM/YYYY
		/	/
		/	/
		/	/
		/	/
		/	/

Service history

10 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

11 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 DD/MM/YYYY
	/ /
	/ /
	/ /

12 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 DD/MM/YYYY
	/ /
	/ /
	/ /

13 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.

First name

Family name

Practice name

Practice address

Postcode

Practice phone

Practice email

Guidance Notes for Medical Practitioner

Doctor or health 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 1

14 Fill out a separate page for each injury or illness you are requesting treatment or **r**ehabilitation for

Condition number **1** — **claimant** to complete

What is the medical condition, injury, or illness you are applying for? Describe any symptoms, for example, pain in left arm, shortness of breath, hearing loss.

When did you first start experiencing this problem?

How has this impacted your daily life?

How do you think your service has caused or contributed to this problem?

Condition number **1** — **Doctor or health practitioner** to complete

What is the diagnosis for the condition described above?

How has this condition been treated in the past?

How is this condition currently being treated?

Describe how this condition has significantly deteriorated since the last assessment.

Is your patient seeing a specialist for this condition, or have they seen a specialist for this condition in the past?

☐ No ☐ Yes **Attach copies of clinical notes and reports from the specialist.**

Enter the specialist name, contact details, and when they were seen.

15 Fill out a separate page for each injury or illness you are requesting treatment or **r**ehabilitation for

Condition number **2** — **claimant** to complete

What is the medical condition, injury, or illness you are applying for? Describe any symptoms, for example, pain in left arm, shortness of breath, hearing loss.

When did you first start experiencing this problem?

How has this impacted your daily life?

How do you think your service has caused or contributed to this problem?

Condition number **2** — **Doctor or health practitioner** to complete

What is the diagnosis for the condition described above?

How has this condition been treated in the past?

How is this condition currently being treated?

Describe how this condition has significantly deteriorated since the last assessment.

Is your patient seeing a specialist for this condition, or have they seen a specialist for this condition in the past?

☐ No ☐ Yes **Attach copies of clinical notes and reports from the specialist.**

Enter the specialist name, contact details, and when they were seen.

Doctor or health practitioner to complete

16 What is your patient's full name?

First name

Middle names

Family name

17 What is your patient's National Health Index (NHI) number, or equivalent in your country?

18 Prior to today when did you last examine the veteran?

D D / M M / Y Y Y Y

19 Are any of the conditions your patient has applied for likely to cause their death within the next 12 months?

☐ No

☐ Yes **Enter the condition below**

20 Is the veteran enrolled with your practice?

☐ No **If no, provide the name and practice of their usual medical practitioner** if known

First name

Family name

Practice name

Practice address

Postcode

Practice phone

Practice email

☐ Yes **If yes, how long have they been enrolled with you?**

Years Months

Doctor or health practitioner to complete *continued …*

21 **Health practitioner information**

First name

Family name

Practice phone

Practice email

What is your CPN (HPI number)?

What is your Medical Council registration number?

Stamp your practice stamp, otherwise write your full contact details

Signature

Today's Date:

D D / M M / Y Y Y Y

Privacy Statement

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 the privacy statement posted to you, please email ***veterans@nzdf.mil.nz*** to request it.

Signature and acknowledgement

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 or by or to named agencies held by any doctor or health practitioner or named agencies, or service providers (such as ACC), 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.

Claimant's or authorised person's signature

Signature of claimant or authorised person:

First names:

Surname:

Today's Date:

D D / M M / Y Y Y Y

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

Helper's relationship to claimant:

First names:

Surname:

Email your completed application form and any supporting documents to:

veterans@nzdf.mil.nz

OR

Send your completed application to:

Veterans' Affairs
PO Box 5146
WELLINGTON 6140