

Employee State Insurance Act

FORM 2

(See rule 20A(2))

Application to Medical Appeal Tribunal Insurance

Insurance No. _____

I _____ (Full name of appellant)
of _____ (Address of appellant) appeal against the
decision on _____ (date) of the Medical Board
at _____ (address) notified to me by letter
(from _____) dated _____

that:

- * (1) there is no appreciable disablement;
- * (2) the disablement should continue to be treated as temporary and the next date when the case should be referred to the Medical Board is; or
- * (3) the disablement can be declared to be of a permanent nature; and
 - (i) the extent of loss of earning capacity can be assessed provisionally or finally;
 - (ii) the assessment of the proportion of loss of earning capacity whether provisional or final; and
 - (iii) in case of provisional assessment, the period for which such assessment shall hold good.

The following are the grounds of my appeal: List of documents, if any.

Date _____

Signature of appellant _____

*Delete whichever does not apply.

The Statement of facts contained in this application is to the best of my knowledge and belief true and correct.

Signature of appellant

To

Chairman of Medical Appeal Tribunal