**Social Security Board**
**P.O. Box 698**
**Road Town, Tortola**
**Virgin Islands**
**Tel:1-284-852-7810 |Fax: 1-284-494-6022**
**Email: info@bvissb.vg | Website: www.bvissb.vg**

# DISABLEMENT BENEFIT CERTIFICATE FOR EMPLOYMENT INJURY

**NAME:** _____ **SOC. SEC. NO.** |  |

**MAILING ADDRESS:** _____

_____

**Tel. Number(s)** _____ **Email Address**_____

**Strike out what does not apply and tick (✓) the appropriate box.**

1. Has there been any change in your condition that has enabled you to work, since you last reported? Yes☐ No ☐
2. Did you work for someone during the last six months? Yes☐ No ☐
3. Did you own your own business during the last six months? Yes☐ No ☐
4. Do you intend to work for your own business or work for someone during the next six months? Yes☐ No ☐

Address (if different from above)

| |
|---|
| |
| |
| |

I declare that all the information given in this document is true. I understand that giving false or misleading information is a serious offense punishable by law.

_____ _____ _____

*Print Name of Beneficiary* *Signature of Beneficiary* *Date*

**TO BE CERTIFIED BY A MEDICAL PRACTITIONER**

**I the undersigned hereby certify that the questions were answered in my presence; that I personally know the signer or that satisfactory evidence to identify the signer has been examined by me and that I have no specific knowledge or reason to believe that the signer has not understood the question, or not responded truthfully. I certify that he/she is still permanently disabled.**

_____ _____ _____

Printed Name Signature Doctor's ID Number

_____ _____

Contact Number Date

**OFFICIAL STAMP/SEAL**