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

INVALIDITY CERTIFICATE

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

MAILING ADDRESS: _____

_____

TELEPHONE 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 or owned a business during the last six months? Yes ☐ No ☐
3. 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 Claimant	Signature of Claimant	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.

_____	_____	_____
Print Name	Signature	Doctor's ID Number

_____	_____
Contact Number	Date

OFFICIAL STAMP/SEAL