Australian Government
Australian Taxation Office

Compassionate release of superannuation – Report by registered medical practitioner

When completing this report

- Print clearly in BLOCK LETTERS using a black pen only.
- Place **X** in ALL applicable boxes.
- Attach the completed report with your application for compassionate release of superannuation.

Section A: **Applicant's details**

The applicant is the person applying to access their super. The applicant can be the patient or someone applying on behalf of a patient.

Your details

1 Name

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

First given name

Other given names

2 Date of birth Day ☐☐ / Month ☐☐ / Year ☐☐☐☐

3 Residential address

Street address

Suburb/town/locality

State/territory ☐☐☐ (Australia only)

Postcode ☐☐☐☐ (Australia only)

Country if outside Australia

Patient's details

Only complete if the patient is different to the applicant

4 Name

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

First given name

Other given names

5 Date of birth Day ☐☐ / Month ☐☐ / Year ☐☐☐☐

6 Residential address

Street address

Suburb/town/locality

State/territory ☐☐☐ (Australia only)

Postcode ☐☐☐☐ (Australia only)

Country if outside Australia

Patient's consent

☐ *I, the patient consent for my medical information contained in this report to be provided to the Commissioner of Taxation.*

Signature of patient or authorised representative (if patient is unable to sign)

Date

Day ☐☐ / Month ☐☐ / Year ☐☐☐☐

Section B: **Application details – Medical practitioner or specialist to complete**

For more information, refer to Guidance for registered medical practitioner on **ato.gov.au**

7 Reason for application?

Medical treatment or transport ☐ Go to **section C**.

Accommodating a disability ☐ Go to **section D**.

Palliative care for terminal illness ☐ Go to **section E**.

! Complete relevant Sections C to E applicable to the patient

Section C: **Medical treatment and/or medical transport**

! The treatment must be for an existing medical condition

8 If applying for medical treatment and/or transport, select why the medical treatment is needed.

☐ Treatment for life threatening illness or injury

A life threatening illness is a medical condition where, within a 12 month time frame, there is a likelihood of severe degeneration or death.

☐ Treatment for acute or chronic pain

Acute means a rapid progress or onset of a condition suggesting urgency of treatment.

Chronic means a condition having indefinite duration or less rapid change. Pain of at least three months duration which may have been stable for some time.

☐ Treatment for acute or chronic mental illness

☐ None of the above – the applicant is not eligible under this category

9 What is the medical condition?

10 What is the medical treatment required?

If client is applying for transport only – go to **question 13**

11 Can the patient access this medical treatment through the public health system?

Yes ☐ go to **question 12**

No ☐ go to **question 13**

12 Is it necessary for the patient to have treatment before it is readily available in the public health system?

Yes ☐ provide details below

No ☐ the applicant is not eligible under this category.

13 If the patient requires transport to access the medical treatment provide details for each treatment location

Treatment location 1

Address where the treatment is provided

How long will the patient require treatment? (The maximum period that can be considered is 52 weeks of medical treatment)

How often must the patient attend medical treatment? Insert number and circle appropriate time period

☐ times per week / month / year

Treatment location 2

Address where the treatment is provided

How long will the patient require treatment? (The maximum period that can be considered is 52 weeks of medical treatment)

How often must the patient attend medical treatment? Insert number and circle appropriate time period

☐ times per week / month / year

Treatment location 3

Address where the treatment is provided

How long will the patient require treatment? (The maximum period that can be considered is 52 weeks of medical treatment)

How often must the patient attend medical treatment? Insert number and circle appropriate time period

☐ times per week / month / year

If additional treatment locations or information needs to be added, attach a separate sheet with details.

Section D: **Accommodating a disability**

14 Does the patient have a severe disability?

A severe disability refers to a severe physical or mental impairment which either temporarily or permanently seriously limits one or more functional capabilities such as mobility, communication and self-care, causing substantial functional limitation in everyday activities.

Yes ☐ go to **question 15**

No ☐ the applicant is not eligible under this category.

15 What modifications or aids are necessary to accommodate the severe disability?

Section E: **Palliative care for a terminal illness**

16 Does the patient have a terminal illness?

Terminal illness refers to an illness or injury that is likely to result in death within 24 months.

Yes ☐ go to **question 17**

No ☐ the applicant is not eligible under this category.

17 What is the palliative care required (ie. homecare, hospice)?

Section F: **Medical practitioner or specialist supporting statement**

The registered medical practitioner needs to be the regular treating doctor for this patient.
The registered medical specialist needs to be a specialist in the field of the medical treatment being categorised as a life threatening illness or injury, acute or chronic pain or acute or chronic mental illness. Generally, a registered medical specialist should be able to comment on the appropriateness of the treatment and the medical condition being treated.

Provide additional comments to support the patient's application if required.

Section G: **Declaration by registered medical practitioner or specialist**

Place **X** in all applicable boxes

☐ I am the registered medical practitioner and the regular treating doctor for this patient, **or**

☐ I am the registered medical specialist in the field of treatment.

☐ I have discussed the content of this report with the applicant/patient.

☐ I declare that the information I am providing is complete and correct.

Name of registered medical practitioner/specialist

AHPRA registration number

Practice address

Practice phone number (include area code)

Field of specialty (mandatory for specialist)

Signature

Date report completed

Day / Month / Year

Registered medical practitioner/specialist stamp (optional)