



APPELLANT'S STATEMENT OF GROUNDS OF APPEAL
THE PSNI & PSNI RESERVE (INJURY BENEFIT) REGULATIONS 2006
APPEAL AGAINST DECISION OF
THE SELECTED MEDICAL PRACTITIONER

Return this form to: Appeals Officer, Police Administration Branch, Northern Ireland Policing Board, 31 Clarendon Road, Clarendon Dock, Belfast BT1 3BG

If you do not have enough space to write all the information we need, please use extra sheets of paper then attach them to this form. You must sign this form, as we cannot accept it without your signature.

1. Under Part 4 Section 30 of the PSNI and PSNI Reserve (Injury Benefit) Regulations 2006, I want to appeal against the Selected Medical Practitioner's Certificate and Report dated:

.....

2. In your own words, set out below, the parts of the Selected Medical Practitioner's Certificate and Report you do not agree with, and the reasons why. You may use a continuation sheet. The reasons for my appeal are as follows:

Horizontal lines for writing the reasons for the appeal.

It is necessary for you to include all important facts to support your case. All involved in the appeal process need to be aware of these issues. The Selected Medical Practitioner may reconsider their decision if, as part of the appeal process, you give new relevant evidence (not new incidents and/or medical conditions).

Please therefore complete either point 3 or point 4 whichever is appropriate:

3. I attach - or will provide within the next 6 weeks - the following supporting documents or information which was not presented to the Selected Medical Practitioner and considered during the initial assessment.

Horizontal lines for listing supporting documents or information.

OR

PROTECTED – MEDICAL

4. I have provided all information in support of my appeal and am content that it proceed to the next step in the process:

Any 'new' information may be referred back to the Selected Medical Practitioner for them to review their decision before your appeal is submitted to the Department of Justice.

5. The following GPs and specialists have treated me for my condition:

Name:Address:

.....

Name:Address:

.....

Name:Address:

.....

Name:Address:

.....

(If necessary, continue on an extra sheet and attach it to this form)

PERSONAL DETAILS

Your signature:..... Date:.....

Fill in the following details in BLOCK CAPITALS

Full Name:

Rank:Service No:

National Insurance Number:

Date you left the Service/Force: (if this applies):

Address:

..... Postcode:

Home Telephone No: Mobile No:

E-mail address (if applicable):

PROTECTED – MEDICAL

REPRESENTATIVE’S DETAILS (Appellants should complete this section ONLY if they wish to appoint a representative to act on their behalf. If using solicitors please only give the name of the firm *not* an individual solicitor)

I authorise the person named below to act as my representative in my appeal. You should send all correspondence relating to my appeal to my representative and I understand you will class this as having been sent to me once my representative receives it. This includes any medical documents relating to my case

Fill in the following details in BLOCK CAPITALS

Full Name:

Position: Phone No:

Address:

..... Postcode:

E-mail address (if you have one):
.....

Your signature: Date:

DECLARATION

As far as I know, the information I have provided is correct. I understand that if any of the information is either misleading or inaccurate, it may affect my application.

I understand that any new incidents and/or medical conditions will not be considered at appeal stage.

I understand that I must provide any and all new supporting evidence before my appeal is submitted to the Department of Justice.

Your signature: _____ **Date:** _____

Contact phone number: _____

We will only use your information for the appeal process, and will only pass it on to the people or organisations involved in this process.

All personal information we hold is processed in accordance with the Data Protection Act 1998.