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|  |  |  | FICHE DE SAISINE DU CONSEIL MEDICAL – FORMATION PLENIERE |  |  |  |
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|  | **IMPORTANT** : Afin de permettre l’instruction de la demande, **l’ensemble des champs doivent obligatoirement être renseignés** et les **pièces demandées jointes au dossier**. En cas d’incomplétude de la saisine, celle-ci vous sera retournée pour compléments. Dans l’attente, l’instruction ne pourra débuter. |  |  |
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|  | **Renseignements concernant l’agent** |  |
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|  | Madame |  |  | Monsieur |  |  |  |  |  | Adresse : |  |  |
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|  | Nom d’usage : |  |  |  | Complément : |  |  |
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|  | Prénom(s) : |  |  |  | Code postal : |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Date de naissance : |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Ville : |  |  |
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|  | Statut applicable : |  | Titulaire |  | Stagiaire |  | Ouvrier d’état |  |  |  |  |  |  |  |  |
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|  | Fonction publique : |  | Etat |  | Territoriale |  | Hospitalière |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Entrée dans l’Adm. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Titularisation : |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Fonction : |  |  |  | Téléphone : |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | NIR : |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Courriel : |  |  |

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|  | **Renseignements concernant le service en charge du dossier** |  |
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|  | Entité juridique\* : |  |  |  | Service RH\*\*\* : |  |  |
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|  | Structure\*\* : |  |  |  | Nom du référent : |  |  |
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|  | Adresse : |  |  |  | Téléphone |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Complément : |  |  |  | Courriel : |  |  |
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|  | Code postal : |  |  |  |  |  |  |  |  |  |  |  |  |  |  | \*Entité juridique de rattachement : Agriculture, Culture, Défense, Economie, Santé, Travail, Justice, etc.\*\*Structure d’affectation : Agence de santé, Centre hospitalier, etc.\*\*\*Service RH : en charge de la gestion du dossier médical de l’agent |  |
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|  | **Renseignements concernant la maladie ou l’accident** |  |
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|  | Maladie professionnelle n° : |  |  |  | Du : |  |  |  |  |  |  |  |  |  | déjà reconnue : |  |  | Oui |  | Non |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Maladie professionnelle n° : |  |  |  | Du : |  |  |  |  |  |  |  |  |  | déjà reconnue : |  |  | Oui |  | Non |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Maladie contractée en service : |  |  | Du : |  |  |  |  |  |  |  |  |  | déjà reconnue : |  |  | Oui |  | Non |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Accident de service ou trajet : |  |  | Du : |  |  |  |  |  |  |  |  |  | déjà reconnue : |  |  | Oui |  | Non |  |  |
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|  | Si reconnaissance, date de reconnaissance : |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  | Directement par l’administration |  |  |  | Après avis de la comission du : |  |  |  |  |  |  |  |  |  |  |  |  |

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|  | **Renseignements concernant le médecin du travail** |  |
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|  | Nom du médecin : |  |  |  | Code postal : |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Adresse :  |  |  |  | Ville : |  |  |
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|  | Complément : |  |  |  |  |  |  |
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|  | **Renseignements concernant la demande** |  |
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|  |  | Accident de service ou accident de trajet : |  |  | Maladies professionnelles : |  |
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|  |  |  |  | Reconnaissance |  |  | Rechute |  |  |  |  |  | Reconnaissance |  |  | Rechute |  |  |
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|  |  | Demande de prise en charge ou prolongation d’arrêts |  | Demande de prise en charge ou prolongation des soins |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | Prise en charge |  |  | Prolongation |  |  |  |  |  | Prise en charge |  |  | Prolongation |  |  |
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|  | Dates  |  |  | Dates  |  |  |  |
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|  |  | Prise en charge des soins post-consolidation |  |  | Constatation de : |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Guérison |  |  | Consolidation |  |  |
|  |  | ATI : Allocation temporaire d’invalidité |  |  | Prise en charge des soins post-consolidation |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | Attribution |  | Révision quinquennale |  | Révision à radiation des cadres (RDC) |  |  |  | Retraite pour invalidité non imputable (+PCI) |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  | Retraite pour invalidité imputable au service (+PCI) |
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|  |  | Cure thermale |  |  | Octroi d’une 4ème période de mise en DORS |
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|  |  | Aptitude/Inaptitude aux fonctions |  |  | Entrée en jouissance immédiate de la pension |
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|  | **Renseignements concernant le(s) expertise(s)** |  |
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|  | Nom du médecin agréé ayant effectué :  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | * L’expertise :
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|  | * Une contre-expertise (option) :
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|  | *Rappel : les rapports d’expertises sont à joindre au dossier lors de la saisine du conseil* |  |
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|  | **Renseignements concernant les représentants (à ne renseigner que lorsque l’agent relève de la FPE)** |  |
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|  | *Représentants d’administration (chef de service dont dépend l’intéressé ou son représentant)* |  |
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|  | Nom : |  |  |  | Courriel : |  |  |
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|  | Adresse :  |  |  |  | Code postal : |  |  |  |  |  |  |  | Ville :  |  |  |
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|  | *Représentant du personnel* |  |
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|  | Nom : |  |  |  | Courriel : |  |  |
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|  | Adresse :  |  |  |  | Code postal : |  |  |  |  |  |  |  | Ville :  |  |  |
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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Cachet de l’administration |  | Signature du chef de service |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Fait à : |  |  |  |  |  |  |  |
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|  | Le : |  |  |  |  |  |  |  |
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