




**REPUBLIC OF THE GAMBIA**  
THE GAMBIA NURSES & MIDWIVES  
COUNCIL

NAME: BUKARY GAYE  
DOB: 28/06/1987  
REG NO. 4707  
INITIAL REG DATE: 08/08/2024  
REG TYPE: A  
VALID UNTIL: 31/12/2025  
REGISTRAR  
Signature: 



IF FOUND, KINDLY TAKE IT TO THE NEAREST HEALTH FACILITY/INSTITUTION /POLICE STATION OR CALL (+220)4225525 EMAIL: [nursingcouncil@ganel.gm](mailto:nursingcouncil@ganel.gm)



A-REGISTERED NURSE

THE BEARER OF THIS LICENSE IS REGISTERED WITH THIS COUNCIL TO PRACTISE AS:

Return to Sedgwick  
P.O. Box 182808  
Columbus, OH 43218-2808  
Fax: 888-436-9535 | Phone: 888-436-9530

Patient Name: FANTA BAKAYOKO  
Claim Number: 2024-0188164

Will the patient need to have treatment visits at least twice per year due to the condition? \_\_\_ No  Yes

Was medication, other than over-the-counter medication, prescribed? \_\_\_ No  Yes

Was the patient referred to any other health care provider(s) for evaluation or treatment (e.g., physical therapist)  
\_\_\_ No  Yes

If yes, state the nature of such treatments and expected duration of treatment:

The patient was referred for ICU Management which lasts > 2 weeks  
B.G

2. Is the medical condition pregnancy?  No \_\_\_ Yes If so, expected delivery date: \_\_\_\_\_
3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

NOTE: In California and Connecticut, do not disclose the underlying diagnosis unless you have received consent from the patient.

Diagnosis: Diabetic ketoacidosis + coma  
Patient requires close monitoring, observation and intensive management.

**PART B: AMOUNT OF CARE NEEDED:**

When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? \_\_\_ No  Yes

If yes, estimate the beginning and ending dates for the period of incapacity: 15/11/24 - 22/12/24

During this time, will the patient need care? \_\_\_ No \_\_\_ Yes

B.G

Explain the care needed by the patient and why such care is medically necessary:

Patient will need care with activities of daily living including frequent turning of the patient to prevent pressure sores.