

Attending Physician's Statement - Disability Claim

Note: **PLEASE SIGN ON ALL PAGES AT BOTTOM.**

DOCTOR'S DETAILS:

Name of the Attending Physician: _____

Name of the Clinic / Hospital: _____

Address: _____

Contact No.: _____ E-mail address: _____

CLAIMANT/PATIENT'S DETAILS:

Name of the Claimant: _____

Address: _____

Age & Sex: _____ Hospital/Indoor Patient Number: _____

SPECIFY WHICH DISABILITY IS APPLICABLE:

- | | | |
|---|---|--|
| <input type="checkbox"/> Loss of sight of one Eye | <input type="checkbox"/> Loss on use of one Limb | <input type="checkbox"/> Loss of sight of both the eyes |
| <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Loss of use of two limbs | <input type="checkbox"/> Loss of one limb & loss of sight of one eye |
| <input type="checkbox"/> Loss of speech and hearing | <input type="checkbox"/> Loss of Speech | |

HISTORY

Date of first Consultation: _____

Details of the Doctor who treated first: _____

Date of appearance of first symptoms: _____

Has the patient ever had the same or similar condition in past: Yes No

(If "yes," state when and provide details. Kindly attach another sheet if required): _____

PRESENT CONDITION:

Subjective symptoms: _____

Objective findings (include results of current X-rays, ECGs or any other special tests): _____

DIAGNOSIS:

Please provide details: _____

TREATMENT:

Date of first visit: _____

OP Number/Hospital No/Indoor Patient No.: _____

Date of last visit: _____ Frequency of visits (Weekly/Monthly/Other): _____

Date of Last examination: _____

Is this Disability permanent: _____

Is this Disability Reversible: _____

What was the cause of disability: _____

Is this disability result of Accident: _____

PROGRESS:

Recovered Improved Unimproved Retrogressed

MENTAL CONDITION:

Is the patient competent to endorse checks and direct the use of proceeds there of? Yes No

DECLARATION:

These statements are true and complete to the best of my knowledge and belief.

Name & Signature of the Physician: _____

Date: _____

Qualifications: _____

Reg. No.: _____

(Seal)