PART2

ShowRequest.java

import java.io.IOException;

import javax.servlet.ServletException;

import java.io.PrintWriter;

import javax.servlet.http.HttpServlet;

import javax.servlet.http.HttpServletResponse;

import javax.servlet.http.HttpServletRequest;

import java.util.Enumeration;

public class ShowRequest extends HttpServlet{

public void doGet(HttpServletRequest req,HttpServletResponse res)throws ServletException,IOException{

res.setContentType("text/html");

PrintWriter out=res.getWriter();

out.println("<html>");

out.println("<head><title>This is the first lab</title></head>");

out.println("<body bgcolor='gray'><b>Request URI:</b>"+req.getRequestURI());

out.println("<hr>");

out.println("<table>");

Enumeration headers=req.getHeaderNames();

while(headers.hasMoreElements())

{

String header=(String)headers.nextElement();

//out.println("<p>headers are here</p>");

out.println("<tr><td>"+header+"</td>");

out.println("<td>"+req.getHeader(header)+"</td></tr>");

}

//out.println("<p>header value</p>");

String headerValue = req.getHeader(req.getHeaderNames().nextElement());

out.print("Header Value:" + headerValue);

out.println("</table>");

out.println("</body>");

out.println("</html>");

}

public void doPost(HttpServletRequest req,HttpServletResponse res)throws ServletException,IOException{

doGet(req,res);

}

}

WEB.XML

<web-app>

<servlet>

<servlet-name>lab1</servlet-name>

<servlet-class>ShowRequest</servlet-class>

</servlet>

<servlet-mapping>

<servlet-name>lab1</servlet-name>

<url-pattern>/ShowRequest</url-pattern>

</servlet-mapping>

</web-app>

PART 3.2

form.java

import java.io.IOException;

import javax.servlet.ServletException;

import java.io.PrintWriter;

import javax.servlet.http.HttpServlet;

import javax.servlet.http.HttpServletResponse;

import javax.servlet.http.HttpServletRequest;

import java.util.Enumeration;

public class form extends HttpServlet{

public void doPost(HttpServletRequest req,HttpServletResponse res)throws ServletException,IOException{

res.setContentType("text/html");

PrintWriter out=res.getWriter();

out.println("<html>");

out.println("<head><title>This is the form</title></head>");

out.println("<body bgcolor='gray'><b>Request URI:</b>"+req.getRequestURI());

out.println("<hr>");

out.println("<label><h2>1.General Information</h2></label>");

out.println("<label><h3>Your Information:</h3></label>");

out.println("<label><h4>Name:</h4></label>"+req.getParameter("cust\_name")+"<br>");

out.println("Address:"+req.getParameter("address")+"<br>");

out.println("City,State,Zip:"+req.getParameter("city\_state\_zip"));

out.println("Phone:"+req.getParameter("phone")+"<br>");

out.println("Email:"+req.getParameter("email")+"<br>");

out.println("<label><h3>Pet Information:</h3></label>"+"<br>");

out.println("Account No:"+req.getParameter("account\_No")+"<br>");

out.println("Pet Name:"+req.getParameter("pet\_name")+"<br>");

out.println("Breed:"+req.getParameter("breed")+"<br>");

out.println("Age:"+req.getParameter("age")+"<br>");

out.println("Gender:"+req.getParameter("gender")+"<br>");

out.println("<label><h2>2.Daignosy/Symptom Information</h2></label>"+"<br>");

out.println("<label><h4>Story of Occurence/Diagnosis</h4</label>"+"<br>");

out.println(req.getParameter("comment")+"<br>");

out.println("<label><h4>The claim is related to:</h4</label>"+req.getParameter("accident")+"<br>");

out.println("Veternarian"+req.getParameter("veternarian")+"<br>");

out.println("<label><h4>is this claim is estimate for future treatment?</h4></label>"+req.getParameter("accident1")+"<br>");

out.println("<label><h4>Clinic Name:</h4></label>"+req.getParameter("clinic\_name")+"<br>");

out.println("<label><h4>Total amount claimed:</h4</label>"+req.getParameter("amnt\_claim")+"<br>");

out.println("Phone:"+req.getParameter("phone1")+"<br>");

out.println("Fax:"+req.getParameter("fax")+"<br>");

out.println("<label><h4>Date illness/injury first occured:</h4</label>"+req.getParameter("amnt\_claim")+"<br>");

out.println("<label><h4>Did any veternarian treat you pet?:</h4></label>"+req.getParameter("veterinarian1")+"<br>");

out.println("<label><h4>Send payment to :</h4</label>"+req.getParameter("me")+"<br>");

out.println("<label><h4>Is this new condition?:</h4></label>"+req.getParameter("condition")+"<br>");

out.println("<label><h2>3.Pet Owner Declaration:</h2></label>"+"<br>");

out.println("<label><h6>I confirm to the best of my knowledge the above statements are true in every respect. I understand that the fees listed may not be covered or may exceed my plan benefit. I understand that I am financially responsible to my veterinarian for the entire treatment. I understand that this claim cannot be adjusted without itemized receipts. I also understand that the deliberate misrepresentation of the animal's condition or the omission of any material facts may result in the denial of the claim and/or the cancellation of coverage. I authorize United States Fire Insurance Company and its business partners to review and obtain a copy of ALL RECORDS including the insurance claim records and medical records as to examination, history, diagnosis, treatment and prognosis with respect to any condition. I further authorize these entities to disclose identifying information about me and my pet, as well as information about my claim experience, to my veterinarian.</h6></label>"+"<br>");

out.println("<label><h4>Signature of pet owner:</h4></label>"+req.getParameter("sign")+"<br>");

out.println("Date:"+req.getParameter("date")+"<br>");

out.println("</body>");

out.println("</html>");

}

}

form.html

<!DOCTYPE html>

<html lang="en">

<head>

<title>Pre-Insurance-Claim-Form</title>

<meta charset="utf-8">

<meta name="viewport" content="width=device-width, initial-scale=1">

<link rel="stylesheet" href="http://maxcdn.bootstrapcdn.com/bootstrap/3.3.6/css/bootstrap.min.css">

<script src="https://ajax.googleapis.com/ajax/libs/jquery/1.12.0/jquery.min.js"></script>

<script src="http://maxcdn.bootstrapcdn.com/bootstrap/3.3.6/js/bootstrap.min.js"></script>

<!-- Include jQuery -->

<script type="text/javascript" src="https://code.jquery.com/jquery-1.11.3.min.js"></script>

<!-- Include Date Range Picker -->

<script type="text/javascript" src="https://cdnjs.cloudflare.com/ajax/libs/bootstrap-datepicker/1.4.1/js/bootstrap-datepicker.min.js"></script>

<link rel="stylesheet" href="https://cdnjs.cloudflare.com/ajax/libs/bootstrap-datepicker/1.4.1/css/bootstrap-datepicker3.css"/>

<style>

.story\_occure{border-style: solid;}

</style>

</head>

<body>

<div class="container">

<form class="form-horizontal" id="ins\_form" action="form" method="post">

<div class="row form-inline">

<div class="col-md-12">

<div class="col-md-4">

<label><h2>1.General Information</h2></label>

</div>

<div class="bottom-aligned-text col-md-8">

<label><h6><i>Please fill out this form completely. Incomplete form will delay processing.</i></h6></label>

</div>

</div>

<hr>

</div>

<b><hr></b>

<div class="row form-inline">

<div class="col-md-6">

<label><h3>Your Information:</h3></label>

</div>

<div class="col-md-6">

<label><h3>Pet Information:</h3></label>

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>Name:</h4></label>

<input type="text" class="form-control" name="cust\_name">

</div>

<div class="col-md-6">

<label><h4>Account No:</h4></label>

<input type="text" class="form-control" name="account\_No">

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>Address:</h4></label>

<input type="text" class="form-control" name="address">

</div>

<div class="col-md-6">

<label><h4>Name:</h4></label>

<input type="text" class="form-control" name="pet\_name">

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>City,State,Zip:</h4></label>

<input type="text" class="form-control" name="city\_state\_zip">

</div>

<div class="col-md-6">

<label><h4>Breed:</h4></label>

<input type="text" class="form-control" name="breed">

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<div class="col-md-6">

<label><h4>Phone:</h4></label>

<input type="text" class="form-control" name="phone">

</div>

<div class="col-md-6">

<label><h4>Email:</h4></label>

<input type="text" class="form-control" name="email">

</div>

</div>

<div class="col-md-6">

<div class="col-md-6">

<label><h4>Age:</h4></label>

<input type="text" class="form-control" name="age">

</div>

<div class="col-md-6">

<label><h4>Gender:</h4></label>

<input type="text" class="form-control" name="gender">

</div>

</div>

</div><!--end of 1st section-->

<div class="row form-inline">

<div class="col-md-12">

<div class="col-md-6">

<label><h2>2.Daignosy/Symptom Information</h2></label>

</div>

<div class="bottom-aligned-text col-md-6">

<label><h6><i>HELP US! By providing the "Story of Occurrence of Daignosy" you will help us avoid processind your delays</i></h6></label>

</div>

</div>

</div>

<hr>

<div class="story\_occure">

<div class="row form-inline">

<div class="col-md-12">

<div class="col-md-6">

<label><h4>Story of Occurence/Diagnosis</h4</label>

</div>

<div class="bottom-aligned-text col-md-6">

<label><h6><i>-Please describe the incident, including dates, details and symptons leading up to it.</i></h6></label>

</div>

<div class="col-md-12">

<textarea class="form-control" rows="3" name="comment"></textarea>

</div>

</div>

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>The claim is related to:</h4</label>

<input type="checkbox" name="accident" value="Accident">Accident

<input type="checkbox" name="accident" value="Illness">Illness

<input type="checkbox" name="accident" value="Wellness">Wellness

</div>

<div class="col-md-6">

<label><h4>Veternarian</h4></label>

<input type="text" class="form-control" name="veternarian">

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>is this claim is estimate for future treatment?</h4</label>

<input type="checkbox" name="accident1" value="Yes">Yes

<input type="checkbox" name="accident1" value="No">No

</div>

<div class="col-md-6">

<label><h4>Clinic Name:</h4></label>

<input type="text" class="form-control" name="clinic\_name">

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>Total amount claimed:</h4</label>

<input type="text" class="form-control" name="amnt\_claim">

</div>

<div class="col-md-6">

<label><h4>Phone:</h4></label>

<input type="text" class="form-control" name="phone1">

<label><h4>Fax:</h4></label>

<input type="text" class="form-control" name="fax">

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>Date illness/injury first occured:</h4</label>

<input type="text" class="form-control" name="amnt\_claim">

</div>

<div class="col-md-6">

<label><h4>Did any veternarian treat you pet?:</h4></label>

<input type="checkbox" class="form-control" name="veterinarian1" value="Yes">Yes

<input type="checkbox" class="form-control" name="veterinarian1" value="No">No

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>Send payment to :</h4</label>

<input type="checkbox" class="form-control" name="me" value="Me">Me

<input type="checkbox" class="form-control" name="me" value="Veternarian">Veternarian

</div>

<div class="col-md-6">

<label><h4>Is this new condition?:</h4></label>

<input type="checkbox" class="form-control" name="condition" value="Yes">Yes

<input type="checkbox" class="form-control" name="condition" value="No">No

</div>

</div><!--end of 2nd -->

<div class="row form-inline">

<div class="col-md-12">

<div class="col-md-6">

<label><h2>3.Pet Owner Declaration:</h2></label>

</div>

</div>

</div>

<hr>

<div class="row form-inline">

<div class="col-md-12">

<label><h6>I confirm to the best of my knowledge the above statements are true in every respect. I understand that the fees listed may not be covered or may exceed my plan benefit. I understand that I am financially responsible to my veterinarian for the entire treatment. I understand that this claim cannot be adjusted without itemized receipts. I also understand that the deliberate misrepresentation of the animal's condition or the omission of any material facts may result in the denial of the claim and/or the cancellation of coverage. I authorize United States Fire Insurance Company and its business partners to review and obtain a copy of ALL RECORDS including the insurance claim records and medical records as to examination, history, diagnosis, treatment and prognosis with respect to any condition. I further authorize these entities to disclose identifying information about me and my pet, as well as information about my claim experience, to my veterinarian.

</h6></label>

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>Signature of pet owner:</h4></label>

<input type="text" class="form-control" name="sign">

</div>

<div class="col-md-6 date">

<label class="control-label" for="date">Date</label>

<div class="input-group input-append date" id="dateRangePicker">

<input class="form-control" id="date" name="date" placeholder="MM/DD/YYY" type="text"/>

<span class="input-group-addon add-on"><span class="glyphicon glyphicon-calendar"></span></span>

</div>

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<button type="submit" class="btn btn-default">Submit</button>

</div>

</div>

<!----------------------------------------------------------------------------------------------------------->

<script>

$(document).ready(function() {

$('#dateRangePicker')

.datepicker({

format: 'mm/dd/yyyy',

startDate: '01/01/2010',

endDate: '12/30/2020'

})

.on('changeDate', function(e) {

// Revalidate the date field

$('#ins\_form').formValidation('revalidateField', 'date');

});

$('#ins\_form').formValidation({

framework: 'bootstrap',

icon: {

valid: 'glyphicon glyphicon-ok',

invalid: 'glyphicon glyphicon-remove',

validating: 'glyphicon glyphicon-refresh'

},

fields: {

date: {

validators: {

notEmpty: {

message: 'The date is required'

},

date: {

format: 'MM/DD/YYYY',

min: '01/01/2010',

max: '12/30/2020',

message: 'The date is not a valid'

}

}

}

}

});

});

</script>

</form>

</div>

</body>

</html>

web.xml

<web-app>

<servlet>

<servlet-name>Assignment1\_3\_1</servlet-name>

<servlet-class>form</servlet-class>

</servlet>

<servlet-mapping>

<servlet-name>Assignment1\_3\_1</servlet-name>

<url-pattern>/form</url-pattern>

</servlet-mapping>

<welcome-file-list>

<welcome-file>form.html</welcome-file>

</welcome-file-list>

</web-app>

PART 4

form.java

import java.io.IOException;

import java.io.PrintWriter;

import java.util.Iterator;

import java.util.Map;

import java.util.Set;

import javax.servlet.ServletException;

import javax.servlet.http.HttpServlet;

import javax.servlet.http.HttpServletResponse;

import javax.servlet.http.HttpServletRequest;

public class form extends HttpServlet{

protected void doPost(HttpServletRequest req,HttpServletResponse res)throws ServletException,IOException

{

PrintWriter pw=res.getWriter();

res.setContentType("text/html");

Map m=req.getParameterMap();

Set s = m.entrySet();

Iterator it = s.iterator();

while(it.hasNext()){

Map.Entry<String,String[]> entry = (Map.Entry<String,String[]>)it.next();

String key = entry.getKey();

String[] value = entry.getValue();

pw.println("Key is "+key+"<br>");

if(value.length>1){

for (int i = 0; i < value.length; i++) {

pw.println("<li>" + value[i].toString() + "</li><br>");

}

}else

pw.println("Value is "+value[0].toString()+"<br>");

pw.println("-------------------<br>");

}

pw.close();

}

}

form.html

<!DOCTYPE html>

<!--onParameterMap-->

<html lang="en">

<head>

<title>Pre-Insurance-Claim-Form</title>

<meta charset="utf-8">

<meta name="viewport" content="width=device-width, initial-scale=1">

<link rel="stylesheet" href="http://maxcdn.bootstrapcdn.com/bootstrap/3.3.6/css/bootstrap.min.css">

<script src="https://ajax.googleapis.com/ajax/libs/jquery/1.12.0/jquery.min.js"></script>

<script src="http://maxcdn.bootstrapcdn.com/bootstrap/3.3.6/js/bootstrap.min.js"></script>

<!-- Include jQuery -->

<script type="text/javascript" src="https://code.jquery.com/jquery-1.11.3.min.js"></script>

<!-- Include Date Range Picker -->

<script type="text/javascript" src="https://cdnjs.cloudflare.com/ajax/libs/bootstrap-datepicker/1.4.1/js/bootstrap-datepicker.min.js"></script>

<link rel="stylesheet" href="https://cdnjs.cloudflare.com/ajax/libs/bootstrap-datepicker/1.4.1/css/bootstrap-datepicker3.css"/>

<style>

.story\_occure{border-style: solid;}

</style>

</head>

<body>

<div class="container">

<form class="form-horizontal" id="ins\_form" action="form" method="post">

<div class="row form-inline">

<div class="col-md-12">

<div class="col-md-4">

<label><h2>1.General Information</h2></label>

</div>

<div class="bottom-aligned-text col-md-8">

<label><h6><i>Please fill out this form completely. Incomplete form will delay processing.</i></h6></label>

</div>

</div>

<hr>

</div>

<b><hr></b>

<div class="row form-inline">

<div class="col-md-6">

<label><h3>Your Information:</h3></label>

</div>

<div class="col-md-6">

<label><h3>Pet Information:</h3></label>

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>Name:</h4></label>

<input type="text" class="form-control" name="cust\_name">

</div>

<div class="col-md-6">

<label><h4>Account No:</h4></label>

<input type="text" class="form-control" name="account\_No">

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>Address:</h4></label>

<input type="text" class="form-control" name="address">

</div>

<div class="col-md-6">

<label><h4>Name:</h4></label>

<input type="text" class="form-control" name="pet\_name">

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>City,State,Zip:</h4></label>

<input type="text" class="form-control" name="city\_state\_zip">

</div>

<div class="col-md-6">

<label><h4>Breed:</h4></label>

<input type="text" class="form-control" name="breed">

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<div class="col-md-6">

<label><h4>Phone:</h4></label>

<input type="text" class="form-control" name="phone">

</div>

<div class="col-md-6">

<label><h4>Email:</h4></label>

<input type="text" class="form-control" name="email">

</div>

</div>

<div class="col-md-6">

<div class="col-md-6">

<label><h4>Age:</h4></label>

<input type="text" class="form-control" name="age">

</div>

<div class="col-md-6">

<label><h4>Gender:</h4></label>

<input type="text" class="form-control" name="gender">

</div>

</div>

</div><!--end of 1st section-->

<div class="row form-inline">

<div class="col-md-12">

<div class="col-md-6">

<label><h2>2.Daignosy/Symptom Information</h2></label>

</div>

<div class="bottom-aligned-text col-md-6">

<label><h6><i>HELP US! By providing the "Story of Occurrence of Daignosy" you will help us avoid processind your delays</i></h6></label>

</div>

</div>

</div>

<hr>

<div class="story\_occure">

<div class="row form-inline">

<div class="col-md-12">

<div class="col-md-6">

<label><h4>Story of Occurence/Diagnosis</h4></label>

</div>

<div class="bottom-aligned-text col-md-6">

<label><h6><i>-Please describe the incident, including dates, details and symptons leading up to it.</i></h6></label>

</div>

<div class="col-md-12">

<textarea class="form-control" rows="3" name="comment"></textarea>

</div>

</div>

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>The claim is related to:</h4</label>

<input type="checkbox" name="accident" value="Accident">Accident

<input type="checkbox" name="accident" value="Illness">Illness

<input type="checkbox" name="accident" value="Wellness">Wellness

</div>

<div class="col-md-6">

<label><h4>Veternarian</h4></label>

<input type="text" class="form-control" name="veternarian">

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>is this claim is estimate for future treatment?</h4></label>

<input type="checkbox" name="accident1" value="Yes">Yes

<input type="checkbox" name="accident1" value="No">No

</div>

<div class="col-md-6">

<label><h4>Clinic Name:</h4></label>

<input type="text" class="form-control" name="clinic\_name">

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>Total amount claimed:</h4</label>

<input type="text" class="form-control" name="amnt\_claim">

</div>

<div class="col-md-6">

<label><h4>Phone:</h4></label>

<input type="text" class="form-control" name="phone1">

<label><h4>Fax:</h4></label>

<input type="text" class="form-control" name="fax">

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>Date illness/injury first occured:</h4</label>

<input type="text" class="form-control" name="amnt\_claim">

</div>

<div class="col-md-6">

<label><h4>Did any veternarian treat you pet?:</h4></label>

<input type="checkbox" class="form-control" name="veterinarian1" value="Yes">Yes

<input type="checkbox" class="form-control" name="veterinarian1" value="No">No

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>Send payment to :</h4</label>

<input type="checkbox" class="form-control" name="me" value="Me">Me

<input type="checkbox" class="form-control" name="me" value="Veternarian">Veternarian

</div>

<div class="col-md-6">

<label><h4>Is this new condition?:</h4></label>

<input type="checkbox" class="form-control" name="condition" value="Yes">Yes

<input type="checkbox" class="form-control" name="condition" value="No">No

</div>

</div><!--end of 2nd -->

<div class="row form-inline">

<div class="col-md-12">

<div class="col-md-6">

<label><h2>3.Pet Owner Declaration:</h2></label>

</div>

</div>

</div>

<hr>

<div class="row form-inline">

<div class="col-md-12">

<label><h6>I confirm to the best of my knowledge the above statements are true in every respect. I understand that the fees listed may not be covered or may exceed my plan benefit. I understand that I am financially responsible to my veterinarian for the entire treatment. I understand that this claim cannot be adjusted without itemized receipts. I also understand that the deliberate misrepresentation of the animal's condition or the omission of any material facts may result in the denial of the claim and/or the cancellation of coverage. I authorize United States Fire Insurance Company and its business partners to review and obtain a copy of ALL RECORDS including the insurance claim records and medical records as to examination, history, diagnosis, treatment and prognosis with respect to any condition. I further authorize these entities to disclose identifying information about me and my pet, as well as information about my claim experience, to my veterinarian.

</h6></label>

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>Signature of pet owner:</h4></label>

<input type="text" class="form-control" name="sign">

</div>

<div class="col-md-6 date">

<label class="control-label" for="date">Date</label>

<div class="input-group input-append date" id="dateRangePicker">

<input class="form-control" id="date" name="date" placeholder="MM/DD/YYY" type="text"/>

<span class="input-group-addon add-on"><span class="glyphicon glyphicon-calendar"></span></span>

</div>

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<button type="submit" class="btn btn-default">Submit</button>

</div>

</div>

<!----------------------------------------------------------------------------------------------------------->

<script>

$(document).ready(function() {

$('#dateRangePicker')

.datepicker({

format: 'mm/dd/yyyy',

startDate: '01/01/2010',

endDate: '12/30/2020'

})

.on('changeDate', function(e) {

// Revalidate the date field

$('#ins\_form').formValidation('revalidateField', 'date');

});

$('#ins\_form').formValidation({

framework: 'bootstrap',

icon: {

valid: 'glyphicon glyphicon-ok',

invalid: 'glyphicon glyphicon-remove',

validating: 'glyphicon glyphicon-refresh'

},

fields: {

date: {

validators: {

notEmpty: {

message: 'The date is required'

},

date: {

format: 'MM/DD/YYYY',

min: '01/01/2010',

max: '12/30/2020',

message: 'The date is not a valid'

}

}

}

}

});

});

</script>

</form>

</div>

</body>

</html>

web.xml

<web-app>

<servlet>

<servlet-name>Assignment1\_4</servlet-name>

<servlet-class>form</servlet-class>

</servlet>

<servlet-mapping>

<servlet-name>Assignment1\_4</servlet-name>

<url-pattern>/form\_paramMap</url-pattern>

</servlet-mapping>

<welcome-file-list>

<welcome-file>form.html</welcome-file>

</welcome-file-list>

</web-app>

PART 5

form.java

import java.io.IOException;

import java.io.PrintWriter;

import java.util.Iterator;

import java.util.Map;

import java.util.Set;

import java.util.Enumeration;

import javax.servlet.ServletException;

import javax.servlet.http.HttpServlet;

import javax.servlet.http.HttpServletResponse;

import javax.servlet.http.HttpServletRequest;

public class form extends HttpServlet{

protected void doPost(HttpServletRequest req,HttpServletResponse res)throws ServletException,IOException

{

PrintWriter pw=res.getWriter();

res.setContentType("text/html");

Enumeration en=req.getParameterNames();

while(en.hasMoreElements())

{

Object obj=en.nextElement();

String param=(String)obj;

String value=req.getParameter(param);

pw.println("Parameter Name is '"+param+"' and Parameter Value is '"+value+"'"+"</br>");

}

pw.close();

}

}

form.html

<!DOCTYPE html>

<!--onParameterMap-->

<html lang="en">

<head>

<title>Pre-Insurance-Claim-Form</title>

<meta charset="utf-8">

<meta name="viewport" content="width=device-width, initial-scale=1">

<link rel="stylesheet" href="http://maxcdn.bootstrapcdn.com/bootstrap/3.3.6/css/bootstrap.min.css">

<script src="https://ajax.googleapis.com/ajax/libs/jquery/1.12.0/jquery.min.js"></script>

<script src="http://maxcdn.bootstrapcdn.com/bootstrap/3.3.6/js/bootstrap.min.js"></script>

<!-- Include jQuery -->

<script type="text/javascript" src="https://code.jquery.com/jquery-1.11.3.min.js"></script>

<!-- Include Date Range Picker -->

<script type="text/javascript" src="https://cdnjs.cloudflare.com/ajax/libs/bootstrap-datepicker/1.4.1/js/bootstrap-datepicker.min.js"></script>

<link rel="stylesheet" href="https://cdnjs.cloudflare.com/ajax/libs/bootstrap-datepicker/1.4.1/css/bootstrap-datepicker3.css"/>

<style>

.story\_occure{border-style: solid;}

</style>

</head>

<body>

<div class="container">

<form class="form-horizontal" id="ins\_form" action="form" method="post">

<div class="row form-inline">

<div class="col-md-12">

<div class="col-md-4">

<label><h2>1.General Information</h2></label>

</div>

<div class="bottom-aligned-text col-md-8">

<label><h6><i>Please fill out this form completely. Incomplete form will delay processing.</i></h6></label>

</div>

</div>

<hr>

</div>

<b><hr></b>

<div class="row form-inline">

<div class="col-md-6">

<label><h3>Your Information:</h3></label>

</div>

<div class="col-md-6">

<label><h3>Pet Information:</h3></label>

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>Name:</h4></label>

<input type="text" class="form-control" name="cust\_name">

</div>

<div class="col-md-6">

<label><h4>Account No:</h4></label>

<input type="text" class="form-control" name="account\_No">

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>Address:</h4></label>

<input type="text" class="form-control" name="address">

</div>

<div class="col-md-6">

<label><h4>Name:</h4></label>

<input type="text" class="form-control" name="pet\_name">

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>City,State,Zip:</h4></label>

<input type="text" class="form-control" name="city\_state\_zip">

</div>

<div class="col-md-6">

<label><h4>Breed:</h4></label>

<input type="text" class="form-control" name="breed">

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<div class="col-md-6">

<label><h4>Phone:</h4></label>

<input type="text" class="form-control" name="phone">

</div>

<div class="col-md-6">

<label><h4>Email:</h4></label>

<input type="text" class="form-control" name="email">

</div>

</div>

<div class="col-md-6">

<div class="col-md-6">

<label><h4>Age:</h4></label>

<input type="text" class="form-control" name="age">

</div>

<div class="col-md-6">

<label><h4>Gender:</h4></label>

<input type="text" class="form-control" name="gender">

</div>

</div>

</div><!--end of 1st section-->

<div class="row form-inline">

<div class="col-md-12">

<div class="col-md-6">

<label><h2>2.Daignosy/Symptom Information</h2></label>

</div>

<div class="bottom-aligned-text col-md-6">

<label><h6><i>HELP US! By providing the "Story of Occurrence of Daignosy" you will help us avoid processind your delays</i></h6></label>

</div>

</div>

</div>

<hr>

<div class="story\_occure">

<div class="row form-inline">

<div class="col-md-12">

<div class="col-md-6">

<label><h4>Story of Occurence/Diagnosis</h4</label>

</div>

<div class="bottom-aligned-text col-md-6">

<label><h6><i>-Please describe the incident, including dates, details and symptons leading up to it.</i></h6></label>

</div>

<div class="col-md-12">

<textarea class="form-control" rows="3" name="comment"></textarea>

</div>

</div>

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>The claim is related to:</h4</label>

<input type="checkbox" name="accident" value="Accident">Accident

<input type="checkbox" name="accident" value="Illness">Illness

<input type="checkbox" name="accident" value="Wellness">Wellness

</div>

<div class="col-md-6">

<label><h4>Veternarian</h4></label>

<input type="text" class="form-control" name="veternarian">

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>is this claim is estimate for future treatment?</h4</label>

<input type="checkbox" name="accident" value="Yes">Yes

<input type="checkbox" name="accident" value="No">No

</div>

<div class="col-md-6">

<label><h4>Clinic Name:</h4></label>

<input type="text" class="form-control" name="veternarian">

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>Total amount claimed:</h4</label>

<input type="text" class="form-control" name="amnt\_claim">

</div>

<div class="col-md-6">

<label><h4>Phone:</h4></label>

<input type="text" class="form-control" name="phone">

<label><h4>Fax:</h4></label>

<input type="text" class="form-control" name="fax">

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>Date illness/injury first occured:</h4</label>

<input type="text" class="form-control" name="amnt\_claim">

</div>

<div class="col-md-6">

<label><h4>Did any veternarian treat you pet?:</h4></label>

<input type="checkbox" class="form-control" name="veterinarian" value="Yes">Yes

<input type="checkbox" class="form-control" name="veterinarian" value="No">No

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>Send payment to :</h4</label>

<input type="checkbox" class="form-control" name="me" value="Me">Me

<input type="checkbox" class="form-control" name="me" value="Veternarian">Veternarian

</div>

<div class="col-md-6">

<label><h4>Is this new condition?:</h4></label>

<input type="checkbox" class="form-control" name="condition" value="Yes">Yes

<input type="checkbox" class="form-control" name="condition" value="No">No

</div>

</div><!--end of 2nd -->

<div class="row form-inline">

<div class="col-md-12">

<div class="col-md-6">

<label><h2>3.Pet Owner Declaration:</h2></label>

</div>

</div>

</div>

<hr>

<div class="row form-inline">

<div class="col-md-12">

<label><h6>I confirm to the best of my knowledge the above statements are true in every respect. I understand that the fees listed may not be covered or may exceed my plan benefit. I understand that I am financially responsible to my veterinarian for the entire treatment. I understand that this claim cannot be adjusted without itemized receipts. I also understand that the deliberate misrepresentation of the animal's condition or the omission of any material facts may result in the denial of the claim and/or the cancellation of coverage. I authorize United States Fire Insurance Company and its business partners to review and obtain a copy of ALL RECORDS including the insurance claim records and medical records as to examination, history, diagnosis, treatment and prognosis with respect to any condition. I further authorize these entities to disclose identifying information about me and my pet, as well as information about my claim experience, to my veterinarian.

</h6></label>

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<label><h4>Signature of pet owner:</h4></label>

<input type="text" class="form-control" name="sign">

</div>

<div class="col-md-6 date">

<label class="control-label" for="date">Date</label>

<div class="input-group input-append date" id="dateRangePicker">

<input class="form-control" id="date" name="date" placeholder="MM/DD/YYY" type="text"/>

<span class="input-group-addon add-on"><span class="glyphicon glyphicon-calendar"></span></span>

</div>

</div>

</div>

<div class="row form-inline">

<div class="col-md-6">

<button type="submit" class="btn btn-default">Submit</button>

</div>

</div>

<!----------------------------------------------------------------------------------------------------------->

<script>

$(document).ready(function() {

$('#dateRangePicker')

.datepicker({

format: 'mm/dd/yyyy',

startDate: '01/01/2010',

endDate: '12/30/2020'

})

.on('changeDate', function(e) {

// Revalidate the date field

$('#ins\_form').formValidation('revalidateField', 'date');

});

$('#ins\_form').formValidation({

framework: 'bootstrap',

icon: {

valid: 'glyphicon glyphicon-ok',

invalid: 'glyphicon glyphicon-remove',

validating: 'glyphicon glyphicon-refresh'

},

fields: {

date: {

validators: {

notEmpty: {

message: 'The date is required'

},

date: {

format: 'MM/DD/YYYY',

min: '01/01/2010',

max: '12/30/2020',

message: 'The date is not a valid'

}

}

}

}

});

});

</script>

</form>

</div>

</body>

</html>

web.xml

<web-app>

<servlet>

<servlet-name>Assignment1\_5</servlet-name>

<servlet-class>form</servlet-class>

</servlet>

<servlet-mapping>

<servlet-name>Assignment1\_5</servlet-name>

<url-pattern>/form</url-pattern>

</servlet-mapping>

<welcome-file-list>

<welcome-file>form.html</welcome-file>

</welcome-file-list>

</web-app>

PART 6

form.java

import java.io.IOException;

import java.io.PrintWriter;

import java.util.Iterator;

import java.util.Map;

import java.util.Set;

import java.util.Enumeration;

import javax.servlet.ServletException;

import javax.servlet.http.HttpServlet;

import javax.servlet.http.HttpServletResponse;

import javax.servlet.http.HttpServletRequest;

public class form extends HttpServlet{

public void doGet(HttpServletRequest request, HttpServletResponse response)throws ServletException, IOException{

response.setContentType("text/html");

//RequestDispatcher view = response.getRequestDispatcher("lab2/form.html");

PrintWriter out = response.getWriter();

//Date date;

out.println("check");

//==========================================

/\* out.println("<html>");

out.println("<head><title> form</title></head>");

out.println("<body>");

out.println("<form action='form' method= 'post'>");

out.println("<hr>");

out.println("<label><h2>1.General Information</h2></label>");

out.println("<label><h3>Your Information:</h3></label>");

out.println("Name: <input type='text' name='cust\_name' /></br></br>");

out.println("Address: <input type='text' name='address' value='"+address+"'/></br></br>");

out.println("City, State, Zip: <input type='text' name='city\_state\_zip' value='"+city\_state\_zip+"'/></br></br>");

out.println("Phone: <input type='text' name='phone' value='"+phone+"'/></br></br>");

out.println("Email: <input type='text' name='username' value='"+cust\_name+"'/></br></br>");

out.println("Name: <input type='text' name='email' value='"+email+"'/></br></br>");

out.println("<label><h3>Pet Information:</h3></label>"+"<br>");

out.println("Account No: <input type='text' name='account\_No' value='"+account\_No+"'/></br></br>");

out.println("Pet Name: <input type='text' name='pet\_name' value='"+pet\_name+"'/></br></br>");

out.println("Breed: <input type='text' name='breed' value='"+breed+"'/></br></br>");

out.println("Age: <input type='text' name='age' value='"+age+"'/></br></br>");

out.println("Gender: <input type='text' name='gender' value='"+gender+"'/></br></br>");

out.println("<label><h2>2.Daignosy/Symptom Information</h2></label>"+"<br>");

out.println("<label><h4>Story of Occurence/Diagnosis</h4</label>"+"<br>");

out.println("Comments: <textarea rows='5' cols='20' name='comment'>"+comment+"</textarea></br></br>");

\*/

//--------------------------------

/\* out.println("The claim is related to: <input type='text' name='gender' value='"+gender+"'/></br></br>");

out.println("Gender: <input type='text' name='gender' value='"+gender+"'/></br></br>");

out.println("Gender: <input type='text' name='gender' value='"+gender+"'/></br></br>");

out.println("Gender: <input type='text' name='gender' value='"+gender+"'/></br></br>");

out.println(req.getParameter("comment")+"<br>");

out.println("<label><h4>The claim is related to:</h4</label>"+req.getParameter("accident")+"<br>");

out.println("Veternarian"+req.getParameter("veternarian")+"<br>");

out.println("<label><h4>is this claim is estimate for future treatment?</h4></label>"+req.getParameter("accident1")+"<br>");

out.println("<label><h4>Clinic Name:</h4></label>"+req.getParameter("clinic\_name")+"<br>");

out.println("<label><h4>Total amount claimed:</h4</label>"+req.getParameter("amnt\_claim")+"<br>");

out.println("Phone:"+req.getParameter("phone1")+"<br>");

out.println("Fax:"+req.getParameter("fax")+"<br>");

out.println("<label><h4>Date illness/injury first occured:</h4</label>"+req.getParameter("amnt\_claim")+"<br>");

out.println("<label><h4>Did any veternarian treat you pet?:</h4></label>"+req.getParameter("veterinarian1")+"<br>");

out.println("<label><h4>Send payment to :</h4</label>"+req.getParameter("me")+"<br>");

out.println("<label><h4>Is this new condition?:</h4></label>"+req.getParameter("condition")+"<br>");

out.println("<label><h2>3.Pet Owner Declaration:</h2></label>"+"<br>");

out.println("<label><h6>I confirm to the best of my knowledge the above statements are true in every respect. I understand that the fees listed may not be covered or may exceed my plan benefit. I understand that I am financially responsible to my veterinarian for the entire treatment. I understand that this claim cannot be adjusted without itemized receipts. I also understand that the deliberate misrepresentation of the animal's condition or the omission of any material facts may result in the denial of the claim and/or the cancellation of coverage. I authorize United States Fire Insurance Company and its business partners to review and obtain a copy of ALL RECORDS including the insurance claim records and medical records as to examination, history, diagnosis, treatment and prognosis with respect to any condition. I further authorize these entities to disclose identifying information about me and my pet, as well as information about my claim experience, to my veterinarian.</h6></label>"+"<br>");

out.println("<label><h4>Signature of pet owner:</h4></label>"+req.getParameter("sign")+"<br>");

out.println("Date:"+req.getParameter("date")+"<br>"); \*/

/\* out.println("</form>");

out.println("</body>");

out.println("</html>"); \*/

//==========================================

out.println("<!DOCTYPE html>"+

"<!--onParameterMap-->"+

"<html lang='en'>"+

"<head>"+

"<title>Pre-Insurance-Claim-Form</title>"+

"<meta charset='utf-8'>"+

"<meta name='viewport' content='width=device-width, initial-scale=1'>"+

"<link rel='stylesheet' href='http://maxcdn.bootstrapcdn.com/bootstrap/3.3.6/css/bootstrap.min.css'>"+

"<script src='https://ajax.googleapis.com/ajax/libs/jquery/1.12.0/jquery.min.js'></script>"+

"<script src='http://maxcdn.bootstrapcdn.com/bootstrap/3.3.6/js/bootstrap.min.js'></script>"+

"<!-- Include jQuery -->"+

"<script type='text/javascript' src='https://code.jquery.com/jquery-1.11.3.min.js'></script>"+

"<!-- Include Date Range Picker -->"+

"<script type='text/javascript' src='https://cdnjs.cloudflare.com/ajax/libs/bootstrap-datepicker/1.4.1/js/bootstrap-datepicker.min.j'></script>"+

"<link rel='stylesheet' href='https://cdnjs.cloudflare.com/ajax/libs/bootstrap-datepicker/1.4.1/css/bootstrap-datepicker3.css'/><style>"+

".story\_occure{border-style: solid;}"+

"</style>"+

"</head>"+

"<body>"+

"<div class='container'>"+

"<form class='form-horizontal' id='ins\_form' action='form' method='post'>"+

"<div class='row form-inline'>"+

"<div class='col-md-12'>"+

"<div class='col-md-4'>"+

"<label><h2>1.General Information</h2></label>"+

"</div>"+

"<div class='bottom-aligned-text col-md-8'>"+

"<label><h6><i>Please fill out this form completely. Incomplete form will delay processing.</i></h6></label>"+

"</div>"+

"</div>"+

"<hr>"+

"</div>"+

"<b><hr></b>"+

"<div class='row form-inline'>"+

"<div class='col-md-6'>"+

"<label><h3>Your Information:</h3></label>"+

"</div>"+

"<div class='col-md-6'>"+

"<label><h3>Pet Information:</h3></label>"+

"</div>"+

"</div>"+

"<div class='row form-inline'>"+

"<div class='col-md-6'>"+

"<label><h4>Name:</h4></label>"+

"<input type='text' class='form-control' name='cust\_name'/>"+

"</div>"+

"<div class='col-md-6'>"+

"<label><h4>Account No:</h4></label>"+

"<input type='text' class='form-control' name='account\_No'/>"+

"</div>"+

"</div>"+

"<div class='row form-inline'>"+

"<div class='col-md-6'>"+

"<label><h4>Address:</h4></label>"+

"<input type='text' class='form-control' name='address'>"+

"</div>"+

"<div class='col-md-6'>"+

"<label><h4>Name:</h4></label>"+

"<input type='text' class='form-control' name='pet\_name'>"+

"</div>"+

"</div>"+

"<div class='row form-inline'>"+

"<div class='col-md-6'>"+

"<label><h4>City,State,Zip:</h4></label>"+

"<input type='text' class='form-control' name='city\_state\_zip'>"+

"</div>"+

"<div class='col-md-6'>"+

"<label><h4>Breed:</h4></label>"+

"<input type='text' class='form-control' name='breed'>"+

"</div>"+

"</div>"+

"<div class='row form-inline'>"+

"<div class='col-md-6'>"+

"<div class='col-md-6'>"+

"<label><h4>Phone:</h4></label>"+

"<input type='text' class='form-control' name='phone'>"+

"</div>"+

"<div class='col-md-6'>"+

"<label><h4>Email:</h4></label>"+

"<input type='text' class='form-control' name='email'>"+

"</div>"+

"</div>"+

"<div class='col-md-6'>"+

"<div class='col-md-6'>"+

"<label><h4>Age:</h4></label>"+

"<input type='text' class='form-control' name='age'>"+

"</div>"+

"<div class='col-md-6'>"+

"<label><h4>Gender:</h4></label>"+

"<input type='text' class='form-control' name='gender'>"+

"</div>"+

"</div>"+

"</div><!--end of 1st section-->"+

"<div class='row form-inline'>"+

"<div class='col-md-12'>"+

"<div class='col-md-6'>"+

"<label><h2>2.Daignosy/Symptom Information</h2></label>"+

"</div>"+

"<div class='bottom-aligned-text col-md-6'>"+

"<label><h6><i>HELP US! By providing the 'Story of Occurrence of Daignosy' you will help us avoid processind your delays</i></h6></label>"+

"</div>"+

"</div>"+

"</div>"+

"<hr>"+

"<div class='story\_occure'>"+

"<div class='row form-inline'>"+

"<div class='col-md-12'>"+

"<div class='col-md-6'>"+

"<label><h4>Story of Occurence/Diagnosis</h4</label>"+

"</div>"+

"<div class='bottom-aligned-text col-md-6'>"+

"<label><h6><i>-Please describe the incident, including dates, details and symptons leading up to it.</i></h6></label>"+

"</div>"+

"<div class='col-md-12'>"+

"<textarea class='form-control' rows='3' name='comment'></textarea>"+

"</div>"+

"</div>"+

"</div>"+

"</div>"+

"<div class='row form-inline'>"+

"<div class='col-md-6'>"+

"<label><h4>The claim is related to:</h4</label>"+

"<input type='checkbox' name='accident' value='Accident'>Accident"+

"<input type='checkbox' name='accident' value='Illness'>Illness"+

"<input type='checkbox' name='accident' value='Wellness'>Wellness"+

"</div>"+

"<div class='col-md-6'>"+

"<label><h4>Veternarian</h4></label>"+

"<input type='text' class='form-control' name='veternarian'>"+

"</div>"+

"</div>"+

"<div class='row form-inline'>"+

"<div class='col-md-6'>"+

"<label><h4>is this claim is estimate for future treatment?</h4</label>"+

"<input type='checkbox' name='accident' value='Yes'>Yes"+

"<input type='checkbox' name='accident' value='No'>No"+

"</div>"+

"<div class='col-md-6'>"+

"<label><h4>Clinic Name:</h4></label>"+

"<input type='text' class='orm-control' name='veternarian'>"+

"</div>"+

"</div>"+

"<div class='row form-inline'>"+

"<div class='col-md-6'>"+

"<label><h4>Total amount claimed:</h4</label>"+

"<input type='text' class='form-control' name='amnt\_claim'>"+

"</div>"+

"<div class='col-md-6'>"+

"<label><h4>Phone:</h4></label>"+

"<input type='text' class='form-control' name='phone'>"+

"<label><h4>Fax:</h4></label>"+

"<input type='text' class='form-control' name='fax'>"+

"</div>"+

"</div>"+

"<div class='row form-inline'>"+

"<div class='col-md-6'>"+

"<label><h4>Date illness/injury first occured:</h4</label>"+

"<input type='text' class='form-control' name='amnt\_claim'>"+

"</div>"+

"<div class='col-md-6'>"+

"<label><h4>Did any veternarian treat you pet?:</h4></label>"+

"<input type='checkbox' class='form-control' name='veterinarian' value='Yes'>Yes"+

"<input type='checkbox' class='form-control' name='veterinarian' value='No'>No"+

"</div>"+

"</div>"+

"<div class='row form-inline'>"+

"<div class='col-md-6'>"+

"<label><h4>Send payment to :</h4</label>"+

"<input type='checkbox' class='form-control' name='me' value='Me'>Me"+

"<input type='checkbox' class='form-control' name='me' value='Veternarian'>Veternarian"+

"</div>"+

"<div class='col-md-6'>"+

"<label><h4>Is this new condition?:</h4></label>"+

"<input type='checkbox' class='form-control' name='condition' value='Yes'>Yes"+

"<input type='checkbox' class='form-control' name='condition' value='No'>No"+

"</div>"+

"</div><!--end of 2nd -->"+

"<div class='row form-inline'>"+

"<div class='col-md-12'>"+

"<div class='col-md-6'>"+

"<label><h2>3.Pet Owner Declaration:</h2></label>"+

"</div>"+

"</div>"+

"</div>"+

"<hr>"+

"<div class='row form-inline'>"+

"<div class='col-md-12'>"+

"<label><h6>I confirm to the best of my knowledge the above statements are true in every respect. I understand that the fees listed may not be covered or may exceed my plan benefit. I understand that I am financially responsible to my veterinarian for the entire treatment. I understand that this claim cannot be adjusted without itemized receipts. I also understand that the deliberate misrepresentation of the animal's condition or the omission of any material facts may result in the denial of the claim and/or the cancellation of coverage. I authorize United States Fire Insurance Company and its business partners to review and obtain a copy of ALL RECORDS including the insurance claim records and medical records as to examination, history, diagnosis, treatment and prognosis with respect to any condition. I further authorize these entities to disclose identifying information about me and my pet, as well as information about my claim experience, to my veterinarian.</h6></label>"+

"</div>"+

"</div>"+

"<div class='row form-inline'>"+

"<div class='col-md-6'>"+

"<label><h4>Signature of pet owner:</h4></label>"+

"<input type='text' class='form-control' name='sign'>"+

"</div>"+

"<div class='col-md-6 date'>"+

"<label class='control-label' for='date'>Date</label>"+

"<div class='input-group input-append date' id='dateRangePicker'>"+

"<input class='form-control' id='date' name='date' placeholder='MM/DD/YYY' type='text'/>"+

"<span class='input-group-addon add-on'><span class='glyphicon glyphicon-calendar'></span></span>"+

"</div>"+

"</div>"+

"</div>"+

"<div class='row form-inline'>"+

"<div class='col-md-6'>"+

"<button type='submit' class='btn btn-default'>Submit</button>"+

"</div>"+

"</div>"+

"<!----------------------------------------------------------------------------------------------------------->"+

"<script>"+

"$(document).ready(function() {"+

"$('#dateRangePicker')"+

".datepicker({"+

"format: 'mm/dd/yyyy',"+

"startDate: '01/01/2010',"+

"endDate: '12/30/2020'"+

"})"+

".on('changeDate', function(e) {"+

// Revalidate the date field

"$('#ins\_form').formValidation('revalidateField', 'date');"+

"});"+

" $('#ins\_form').formValidation({"+

"framework: 'bootstrap',"+

"icon: {"+

" valid: 'glyphicon glyphicon-ok',"+

" invalid: 'glyphicon glyphicon-remove',"+

" validating: 'glyphicon glyphicon-refresh'"+

"},"+

"fields: {"+

" date: {"+

" validators: {"+

" notEmpty: {"+

" message: 'The date is required'"+

" },"+

" date: {"+

" format: 'MM/DD/YYYY',"+

" min: '01/01/2010',"+

" max: '12/30/2020',"+

" message: 'The date is not a valid'"+

" }"+

" }"+

"}"+

"}"+

" }); "+

"});"+

"</script>"+

"</form>"+

"</div>"+

"</body>"+

"</html>");

/\* out.println("<head><title> Lab2</title></head>");

out.println("<body>");

out.println("<form action='Lab2' method= 'post'>");

out.println("Name: <input type='text' name='username' value='"+userName+"'/></br></br>");

out.println("Comments: <textarea rows='5' cols='20' name='comments'>"+comments+"</textarea></br></br>");

out.println("<input type='checkbox' name='rememberMe' value='yes'> Remeber me</br>");

out.println("<input type='submit' value='Submit'/>");

out.println("</body>");

out.println("</html>"); \*/

}

public void doPost(HttpServletRequest req,HttpServletResponse res)throws ServletException,IOException{

try{

res.setContentType("text/html");

PrintWriter out=res.getWriter();

out.println("<html>");

out.println("<head><title>This is the form</title></head>");

out.println("<body bgcolor='gray'><b>Request URI:</b>"+req.getRequestURI());

out.println("<hr>");

out.println("<label><h2>1.General Information</h2></label>");

out.println("<label><h3>Your Information:</h3></label>");

out.println("<label><h4>Name:</h4></label>"+req.getParameter("cust\_name")+"<br>");

out.println("Address:"+req.getParameter("address")+"<br>");

out.println("City,State,Zip:"+req.getParameter("city\_state\_zip"));

out.println("Phone:"+req.getParameter("phone")+"<br>");

out.println("Email:"+req.getParameter("email")+"<br>");

out.println("<label><h3>Pet Information:</h3></label>"+"<br>");

out.println("Account No:"+req.getParameter("account\_No")+"<br>");

out.println("Pet Name:"+req.getParameter("pet\_name")+"<br>");

out.println("Breed:"+req.getParameter("breed")+"<br>");

out.println("Age:"+req.getParameter("age")+"<br>");

out.println("Gender:"+req.getParameter("gender")+"<br>");

out.println("<label><h2>2.Daignosy/Symptom Information</h2></label>"+"<br>");

out.println("<label><h4>Story of Occurence/Diagnosis</h4</label>"+"<br>");

out.println(req.getParameter("comment")+"<br>");

out.println("<label><h4>The claim is related to:</h4</label>"+req.getParameter("accident")+"<br>");

out.println("Veternarian"+req.getParameter("veternarian")+"<br>");

out.println("<label><h4>is this claim is estimate for future treatment?</h4></label>"+req.getParameter("accident1")+"<br>");

out.println("<label><h4>Clinic Name:</h4></label>"+req.getParameter("clinic\_name")+"<br>");

out.println("<label><h4>Total amount claimed:</h4</label>"+req.getParameter("amnt\_claim")+"<br>");

out.println("Phone:"+req.getParameter("phone1")+"<br>");

out.println("Fax:"+req.getParameter("fax")+"<br>");

out.println("<label><h4>Date illness/injury first occured:</h4</label>"+req.getParameter("amnt\_claim")+"<br>");

out.println("<label><h4>Did any veternarian treat you pet?:</h4></label>"+req.getParameter("veterinarian1")+"<br>");

out.println("<label><h4>Send payment to :</h4</label>"+req.getParameter("me")+"<br>");

out.println("<label><h4>Is this new condition?:</h4></label>"+req.getParameter("condition")+"<br>");

out.println("<label><h2>3.Pet Owner Declaration:</h2></label>"+"<br>");

out.println("<label><h6>I confirm to the best of my knowledge the above statements are true in every respect. I understand that the fees listed may not be covered or may exceed my plan benefit. I understand that I am financially responsible to my veterinarian for the entire treatment. I understand that this claim cannot be adjusted without itemized receipts. I also understand that the deliberate misrepresentation of the animal's condition or the omission of any material facts may result in the denial of the claim and/or the cancellation of coverage. I authorize United States Fire Insurance Company and its business partners to review and obtain a copy of ALL RECORDS including the insurance claim records and medical records as to examination, history, diagnosis, treatment and prognosis with respect to any condition. I further authorize these entities to disclose identifying information about me and my pet, as well as information about my claim experience, to my veterinarian.</h6></label>"+"<br>");

out.println("<label><h4>Signature of pet owner:</h4></label>"+req.getParameter("sign")+"<br>");

out.println("Date:"+req.getParameter("date")+"<br>");

out.println("</body>");

out.println("</html>");

}catch(Exception e){

System.out.println(e);

}

}

}

Web.xml

<web-app>

<servlet>

<servlet-name>Assignment1\_6</servlet-name>

<servlet-class>form</servlet-class>

</servlet>

<servlet-mapping>

<servlet-name>Assignment1\_6</servlet-name>

<url-pattern>/form</url-pattern>

</servlet-mapping>

</web-app>