



## **Disability Claim Form**(Attending Physician's Statement)

Important Notes:

- 1. This form is to be accomplished by the Attending Physician.
- 2. Please write legibly in BLOCK LETTERS. Do not sign on a blank form.

3. Please shade the circle to indicate your	choice(s).
1. General Information:	
Full Name of the Patient:  Date of Birth: (yyyy/mm/dd)	
2. Your Association with the patient:	
Are you related to the patient? Yes No Relationship:  Are you the attending physician of the patient prior, If "Yes", please provide details below: Date when you first attended the patient  Chief comple	If "Yes", please provide details below:  No. of years you have known the patient  /during his/her disability? Yes No  aints of the patient
3. Particulars of the Disability:  Nature of patient's disability:  Cause of disability:	Date you have diagnosed the disability:
Illness Accident	Bute you have diagnosed the disability.
If disability is due to Illness, please provide details below:	If disability is due to Accident, please provide details below:
Symptoms of illness during the first consultation:	Details of injury(ies) sustained:
Date of first consultation:	Date & time of accident:
Duration of the symptoms:	Place of accident:

FOR OFFICE USE O	NLY
Date Received:	
Time Received:	
Receiving Dept./Of	fice:
FOR DISTRIBUTOR'S	S USE ONLY
FE/Advisor's code:	
FE/Advisor's name:	:

FE/Advisor's mobile number:

Please provide below the details of your diagnosis and the medical treatment/management given to the patient:				
Complete diagnosis: Details of treatment/management:				
Prognosis:				I
How would you classify the	patient's disability?			
○ Total Permanent Disability ○ Total Temporary Disability				
O Partial Permanent D	isability	O Partial To	emporary Disability	
Please shade below the Act perform without assistance		(ADL) that the	Patient is currently UNABLE to	
Ability to feed oneself Ability to get in and out of bed				
Ability to attend to own toilet needs Ability to dres		dress and/or undress oneself		
Ability to wash and b	eath oneself	Ability to	move from room to room on level surface	
Aside from you, did other ph	nysicians attend the p	atient regardi	ing his/her disability?	
-	, please provide detai	ils below:		
Name:			Contact Details:	
4. Details of your pa	ast consultation	s on the pa	atient:	
Date (yyyy/mm/dd)	Diagnosi	s	Treatment	
	<u> </u>			
E. Bastonellanes				
5. Declarations:				
I haraby cortify that I have	norganally avaminad a	nd tracted the	Detient in connection to the chave condition	and
			Patient in connection to the above condition dition. I declare and agree to make the declare	
on this claim form.				
Name of Physician:				
Signature:			Place of Signing:	
одписитот			- May or organize	
			Date of Signing: (yyyy/mm/dd)	
			Date of Signing. (yyyy/mm/dd)	
Field of Specialization:			License No:	
Clinic Address:				
1				
Mohile No :			Clinic Tol. No.	
Mobile No.:			Clinic Tel. No.:	

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