

Please provide below the details of your diagnosis and the medical treatment/management given to the patient:

Complete diagnosis:

Details of treatment/management:

Prognosis:

How would you classify the patient's disability?

- ☐ Total Permanent Disability ☐ Total Temporary Disability
☐ Partial Permanent Disability ☐ Partial Temporary Disability

Please shade below the Activities of Daily Living (ADL) that the Patient is currently UNABLE to perform without assistance:

- ☐ Ability to feed oneself ☐ Ability to get in and out of bed
☐ Ability to attend to own toilet needs ☐ Ability to dress and/or undress oneself
☐ Ability to wash and bath oneself ☐ Ability to move from room to room on level surface

Aside from you, did other physicians attend the patient regarding his/her disability?

☐ Yes ☐ No if "yes", please provide details below:

Name:

Contact Details:

4. Details of your past consultations on the patient:

Date (yyyy/mm/dd)	Diagnosis	Treatment
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

5. Declarations:

I hereby certify that I have personally examined and treated the Patient in connection to the above condition and that the facts as given above present my opinion of his/her condition. I declare and agree to make the declaration on this claim form.

Name of Physician:**Signature:****Place of Signing:****Date of Signing: (yyyy/mm/dd)****Field of Specialization:****License No:****Clinic Address:****Mobile No.:****Clinic Tel. No.:**