Doctor's Report

Patient's First Name/Last Name: _____

Date of Birth: _____

Treated by Doctor/Hospital: _____

Address of Doctor/Hospital: _____

Treatment: _____

_____

_____

Diagnosis: _____

_____

_____

Unable to work? **Yes ☐** **No ☐**

If yes, date from — to: _____

Medical costs: **Total amount:**_____

Additional comments of the doctor: _____

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Date of treatment **Signature & stamp of the doctor**