MNC LIFE

CERTIFICATE OF GENERAL PRACTITIONER/SPECIALIST

I certify that I have personally examined the sickness/injury sustained by the patient mentioned below:

Patient's Name :		Main Complaint :	
ID Number/Medical Record Number:		Other Complaints :	
Patient's Address :			

Sickness/disability onset date :	- - *(dd-mm-yyyy)*
Has the patient ever sustained this kind of sickness before (from anamnesa)? :	Yes No — If yes, please state, when and how long the patient has been hospitalized or under treatment:
Please explain the chronology of sickness/disability when the patient was examined :	
Please mention the symptom(s) felt by the patient :	
Are you the family/personal GP of the patient? :	Yes No
How long has the patient seen you? :	
Please inform us the name and address/phone number of a person who recommended the patient mentioned above :	

Is there any other sickness which provides a basis of the sickness/disability claimed? :	Yes No — If yes, please explain type of sickness:
When was the sickness/disability sustained? :	- - *(dd-mm-yyyy)*

Is there any other sickness(es), such as from :

- Nervous System
- Gastro-intestinal System
- Genito-Urinary System
- Cardio Vascular System
- Respiratory System
- Reproductive System
- Blood System
- Exocrin, Endocrin and Metabolic System
- etc.

Please elaborate the sickness in detail :

What kind of treatment(s) was given to the patient? :	
Please explain and enclose copy of prescription(s) given :	
Please explain and enclose result of supporting examinations done :	
For your point of view, did the sickness/disability need hospitalization? :	Yes No
Was hospitalization requested by patient? :	Yes No
Was the patient need to be hospitalized for more than 12 hours? :	Yes No
Date of hospitalization *(dd-mm-yyy)* :	- - until - -
Was the patient operated at that time? :	Yes No When?:
Type of operation (please state in detail) :	

What was the working diagnosis? :

What was the cause of sickness/disability based on the examination(s) :

What is the cause of death? (for proposing claim of death) :

Date:	*Hospital Name & Address:*	*Doctor's Name & Stamp:*	*Doctor's Address & Contact Number:*	**Physician's Signature:**