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 Complaint :
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 the sickness :
When was the sickness/disability sustained?	:	- - *(dd-mm-yyyy)*

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

Nervous System	Gastro-intestinal System	Gastro-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 precription(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-yyyy)*	:	- - *(dd-mm-yyyy)*
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 :***