

# CERTIFICATE OF GENERAL PRACTITIONER/SPECIALIST

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

Patient's Name :	<input style="width:95%;" type="text"/>	Main Complaint :	<input style="width:95%;" type="text"/>
ID Number/Medical Record Number :	<input style="width:100%;" type="text"/>	Other Complaint :	<input style="width:95%;" type="text"/>
Patient's Address :	<input style="width:100%;" type="text"/>		

Sickness/disability onset date :  -  -  (dd-mm-yyyy)

Has the patient ever sustained this kind of sickness before (from anamnesa) :	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, please state, when and how long the patient has been hospitalized or under treatment:
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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 :

<input type="checkbox"/> Nervous System	<input type="checkbox"/> Gastro-intestinal System	<input type="checkbox"/> Gastro-urinary System
<input type="checkbox"/> Cardio Vascular System	<input type="checkbox"/> Respiratory System	<input type="checkbox"/> Reproductive System
<input type="checkbox"/> Blood System	<input type="checkbox"/> Exocrin, Endocrin and Metabolic System	<input type="checkbox"/> 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-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 :
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