ADAMJEE LIFE ASSURANCE COMPANY LIMITED

PHYSICIAN REPORT

Note: Both Pages and all contents must be completed entirely for this form to be accepted

Policy No. _____ Claim No._____

DETAILS OF INSURED / PATIENT

1. a) Name in full (block letters)_____ Age _____

b) Father's/Husband's Name_____ Contact No _____

DETAILS OF INJURY

a) Date of accident_____(b)Time and Place of accident_____

c) Exact cause of accident and injuries sustained._____

DIAGNOSIS AND DETAILS OF MEDICAL CONDITION

(a) Diagnosis of the condition / Name of injury /Injuries _____

(b) If **Fracture** please Mention Name of Fracture _____

(c) Location / Site of Fracture _____

Was it confirmed by X-ray? Yes ☐ No ☐

d) When did patient first consult you for this condition? _____

e) Described any other disease or infirmity affecting present condition. _____

DETAILS OF TREATMENT

5. State the Details of treatment Given_____

If surgical operation performed, mention : Name of Operation _____

Date of Operation _____ Post Operative Complications _____

RECOVERY AND PROGNOSIS

Please provide the details of the following:

Duration of patient's confinement to Bed: From _____ __ To_____

Duration of Total Disability Due to this Injury: From _____ To_____

Return to Work on _____Current Condition_____

_____

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PHYSICIAN'S AFFIDAVIT OF TEMPORARY TOTAL DISABILITY

I certify that, in the best professional judgment, my patient is temporarily totally disabled as a result of Accidental injury and is unable to attend his job or to be gainfully employed. The cause of the injury is _____

The patient's temporary total disability began on _____. I anticipate that this patient will recover from this disability to the extent that he or she will be able attend his job or to be gainfully employed on _____

I am legally authorized to practice medicine/surgery. I declare that whatever is affirmed is true and correct.

Date:_____ Name of the Attending Physician_____

Signed & Stamp _____