

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: 95%;" type="text"/>	Other Complaint :	<input style="width: 95%;" type="text"/>
Patient's Address :	<input style="width: 95%;" type="text"/>		

Sickness/disability onset date :	<input style="width: 95%;" type="text"/>	- <input style="width: 95%;" type="text"/>	- <input style="width: 95%;" type="text"/>	<small>(dd-mm-yyyy)</small>
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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 :	<input style="width: 95%;" type="text"/>
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Please mention the symptom(s) felt by the patient :	<input style="width: 95%;" type="text"/>
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Are you the family/personal GP of the patient? :	<input type="checkbox"/> Yes <input type="checkbox"/> No
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How long has the patient seen you :	<input style="width: 95%;" type="text"/>
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Please inform us the name and address/phone number of a person who recommended the patient mentioned above :	<input style="width: 95%;" type="text"/>
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Is there any other sickness which provides a basis of the sickness/disability claimed? :	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please explain the sickness : <input style="width: 95%;" type="text"/>
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When was the sickness/disability sustained? :	<input style="width: 95%;" type="text"/>	- <input style="width: 95%;" type="text"/>	- <input style="width: 95%;" type="text"/>	<small>(dd-mm-yyyy)</small>
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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 :	<input style="width: 95%;" type="text"/>
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What kind of treatment(s) was given to the patient? :	<input style="width: 95%;" type="text"/>
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Please explain and enclose copy of prescription(s) given :	<input style="width: 95%;" type="text"/>
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Please explain and enclose result of supporting examinations done :	<input style="width: 95%;" type="text"/>
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For your point of view, did the sickness/disability need hospitalization? :	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input style="width: 95%;" type="text"/>
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Was hospitalization requested by patient? :	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input style="width: 95%;" type="text"/>
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Was the patient need to be hospitalized for more than 12 hours? :	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input style="width: 95%;" type="text"/>
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Date of hospitalization <small>(dd-mm-yyyy)</small> :	<input style="width: 95%;" type="text"/>	- <input style="width: 95%;" type="text"/>	- <input style="width: 95%;" type="text"/>	<small>(dd-mm-yyyy)</small>
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Was the patient operated at that time? :	<input type="checkbox"/> Yes <input type="checkbox"/> No	When?: <input style="width: 95%;" type="text"/>
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Type of operation (please state in detail) :	<input style="width: 95%;" type="text"/>
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What was the working diagnosis? :	<input style="width: 95%;" type="text"/>
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What was the cause of sickness/disability based on the examination(s) :	<input style="width: 95%;" type="text"/>
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What is the cause of death? (for proposing claim of death) :	<input style="width: 95%;" type="text"/>
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Date :	Hospital Name & Address :	Doctor's Name & Stamp :	Doctor's Address & Contact Number:	Physician's Signature :
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