AIA PUBLIC TAKAFUL

ATTENDING PHYSICIAN'S STATEMENT
Female Product– Spina Bifida
To be completed by Registered Medical Practitioner at Person Covered's / Claimant's own expense

Certificate No:	IC No:	Age:
Name of Person Covered:		Gender: ☐ Male ☐ Female

Part I - General Information

1. (a) Are you the Person Covered's usual medical physician? (b) If "Yes", over what period do your records extend?	1. (a) ☐ Yes ☐ No (b) _____
2.. When were you first consulted for this illness?	2. _____ (MM/DD/YYYY)
3. Please state if there is anything in the Person Covered's family history which would have increased the risk of this illness.	3. _____
4. Please provide names, addresses and dates of the Person Covered's consultation with other physicians or medical facilities for this condition.	4. _____
5. How long has the condition been medically documented?	5. _____
6. When was the diagnosis made? Please state the date.	6. _____ (MM/DD/YYYY)

7. Please give details of all investigations conducted as part of the diagnosis (including dates and results). Please attach the relevant reports, echocardiogram, X-ray etc. supporting this diagnosis.

Date	Results

8. Were there clinical manifestations of meningomyelocele or meningocele?

_____

_____

_____

9 Please give details of resultant neurological deficits.

_____

_____

_____

10. Present Condition of the Person Covered.

11. Prognosis.

12. Please state if the Person Covered has previously suffered / been treated for any other illnesses / complaints other than this condition.

13. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.

I hereby certify that I have personally examined and treated the Person Covered for his / her injuries / illnesses described above and that the facts as stated above represent my medical opinion of his / her condition.

Signature of Attending Physician

Qualification: _____

Name & Address: _____

(Official Stamp)

Date: _____

(MM/DD/YYYY)

Contact No.: _____