AIA PUBLIC TAKAFUL

ATTENDING PHYSICIAN'S STATEMENT
Critical Illness – Major Head Trauma
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. Date of Accident	2. (a) _____ (MM/DD/YYYY)
3. (a) When were you first consulted for this injury? (b) What was the condition during the first attendance?	3. (a) _____ (MM/DD/YYYY) (b) _____
4. (a) Was there any visible wound at the first consultation? (b) If "Yes", please describe.	4. (a) ☐ Yes ☐ No (b) _____

5. Please give below the details of any other doctors or specialist you have consulted in connection with this illness.

Names	Addresses	Dates (MM/DD/YYYY)

6. (a) Was the injury induced from or affected by any of the following which may contribute to the accident?

Please check the appropriate item.

- ☐ Physical defects /congenital anomaly
- ☐ Degenerate changes
- ☐ Unfavourable past medical history
- ☐ Alcohol or drugs

(b) If any of the items in Q6 (a) checked, please give details.

_____

_____

_____

_____

7. Investigations Done.

Dates (MM/DD/YYYY)	Procedures	Results
(a)		
(b)		
(c)		

8. (a) Details of Treatment Rendered	8. (a) _____
(b) Was there any surgery performed?	(b) ☐ Yes ☐ No
(c) If "Yes", please provide details of surgical procedures.	(c) _____
9. Is the Person Covered permanently bedridden as a result of the head trauma?	9. ☐ Yes ☐ No
10. (a) If the Person Covered is not bedridden, which of the following daily activities is the Person Covered NOT able to perform as a direct result of the trauma. Please check the appropriate item.	10. (a) ☐ Getting in an out of a chair without requiring physical assistance. ☐ The ability to move from room to room without requiring any physical assistance. ☐ The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene ☐ Putting on and taking off all necessary items of clothing without requiring assistance of another person. ☐ The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means. ☐ All tasks of getting food into the body once it has been prepared.
(b) How long has such inability been medically documented?	(b) _____
(c) Is such inability expected to be permanent?	(c) ☐ Yes ☐ No
11. Prognosis.	11. _____
12. Has the Person Covered suffered from / been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please provide full details.	12. ☐ Yes ☐ No _____
13. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	13. _____

Note: Please enclose copies of all reports including X-rays, CT scan, blood test, other laboratory tests, cytology, surgical report and any relevant hospital reports that are available

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.

_____ Qualification: _____

Signature of Attending Physician

Name & Address: _____ Date: _____

(Official Stamp)

(MM/DD/YYYY)

Contact No.: _____