

(g) Did the patient undergo any surgery? Yes No

If yes, please provide us the following details.

(i) Nature of Surgical Procedure performed: _____

(ii) Date of surgery performed: _____ / _____ / _____
dd mm yyyy

(h) Please provide the period of medical leave given to the patient.

(i) Period of Total Disability*: From _____ To _____

(ii) Period of Partial Disability**: From _____ To _____

Notes: ***Total Disability** refers to disability which prevents the patient from performing each and every duty of his/ her occupation.

****Partial Disability** refers to disability which prevents the patient from performing one or more duties of his/ her occupation.

(i) If the patient is still totally disabled, how long is the total disability expected to last?

(j) If the patient is still partially disabled, how long is the partial disability expected to last?

(k) Was the patient suffering from any illness/ infirmity which was likely to protract the period of disability?

Yes No

If yes, please provide us the details.

(l) Did the patient consult other doctors for this injury before he/ she consulted you?

Yes No

If yes, please provide the name(s) and address(es) of the doctor(s) whom he/ she consulted.

Name of Doctor	Name and Address of Clinic/ Hospital	Dates of Consultation

(m) Has the patient been admitted to hospital before for the same injury? Yes No

If yes, please provide the following details.

Date of Admission	Date of Discharge	Name of Hospital

(n) Please give any other information which you feel would be helpful in assessment of the patient's claim.

Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the patient's claim.

Signature of Doctor

Date

Name and Qualification (printed)

Address & Official Stamp