



# CERTIFICATE OF ATTENDING PHYSICIAN

Hospitalization / Medical Reimbursement Claim

Kindly have this form accomplished by the attending physician.

1.	(a) Full Name of PATIENT First Middle Last	(b) Are you related to the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
		If yes, what is the relationship?
2.	Nature of complaint	<input type="checkbox"/> Accident <input type="checkbox"/> Sickness
3.	What is your Diagnosis? (Please Print)	
4.	What are its contributory causes?	

## Accident Information

5.	Nature of Accident	<input type="checkbox"/> Road Traffic Accident	<input type="checkbox"/> Accidents caused by Machinery		
		<input type="checkbox"/> Hit by a Heavy Object / Person	<input type="checkbox"/> Pricked by a Sharp Object		
		<input type="checkbox"/> Fire, Explosion, Hot Substance	<input type="checkbox"/> Accidental Fall		
		<input type="checkbox"/> Attacked / Bitten by Insect / Animal	<input type="checkbox"/> Cut by Substance / Device		
		<input type="checkbox"/> Natural Disaster / Environmental			
		<input type="checkbox"/> Others	Please Specify:		
6.	Describe the circumstances of the accident fully and briefly				
7.	Date of Accident	mm	dd	yyyy	Time
					<input type="checkbox"/> AM <input type="checkbox"/> PM
	Place of Accident	House No./Street/Bldg			
		Subdivision/Brgy/District			
		Town/City and Province			

## Treatment Information (whether Accident or Sickness)

8.	Outpatient treatment / consultation	<input type="checkbox"/> Yes <input type="checkbox"/> No				
		Date of 1st consultation	mm	dd	yyyy	Consultation Time, if available
					<input type="checkbox"/> AM <input type="checkbox"/> PM	
9.	Hospital Confinement	<input type="checkbox"/> Yes <input type="checkbox"/> No				
		Hospital Name				
		Admission Date	mm	dd	yyyy	Admission Time
						<input type="checkbox"/> AM <input type="checkbox"/> PM
		Discharge Date	mm	dd	yyyy	Discharge Time
				<input type="checkbox"/> AM <input type="checkbox"/> PM		

10.	Was any body part amputated/have lost its use?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Specify body part that was amputated/have lost its use					
11.	(a) Was surgery done?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Type of Surgery					
	(b) Date of Surgery	mm	dd						yyyy
12.	(a) When did the symptoms of the sickness begin?	mm	dd	yyyy	(b) When did the condition first originate?	mm	dd	yyyy	
13.	Names and addresses of all doctors or hospitals who previously treated the patient:								
	Name		Address		Treatment Dates		Disease or Condition		
14.	Is the patient disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No							
		If yes, state duration of disability		from		to			
		mm	dd	yyyy	mm	dd	yyyy		
15.	Is the patient diagnosed with Cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No						
	If yes, please indicate the outpatient and chemotherapy treatments below:								
	Name of Doctor/Clinic		Address		Treatment Dates		Type of treatment		
16.	Is the patient's condition a mental or nervous disorder?					<input type="checkbox"/> Yes	<input type="checkbox"/> No		
17.	Is the treatment related to pregnancy, miscarriage, abortion or childbirth?					<input type="checkbox"/> Yes	<input type="checkbox"/> No		
18.	Is the condition sustained from being intoxicated or under the influence of drugs?					<input type="checkbox"/> Yes	<input type="checkbox"/> No		
19.	Is the condition sustained from alcoholism or drug addiction?					<input type="checkbox"/> Yes	<input type="checkbox"/> No		
20.	Is the treatment for routine physical check-up, rest cure, or special nursing care?					<input type="checkbox"/> Yes	<input type="checkbox"/> No		
21.	Is the patient's condition congenital?					<input type="checkbox"/> Yes	<input type="checkbox"/> No		
22.	Is the treatment for cosmetic reasons, a dental treatment or an elective surgery?					<input type="checkbox"/> Yes	<input type="checkbox"/> No		
23.	Is the treatment for circumcision, sterilization, artificial insemination, sex transformation, or treatment of infertility?					<input type="checkbox"/> Yes	<input type="checkbox"/> No		
24.	Is the patient's condition AIDS-related or due to a sexually transmitted disease?					<input type="checkbox"/> Yes	<input type="checkbox"/> No		

25.	(a) Doctor's Full Name in print			(b) Doctor's Signature				
26.	Doctor's Clinic Address		House No./Street/Bldg					
			Subdivision/Brgy/District					
			Town/City and Province					
27.	(a) PRC License Number			(b) Date this form was accomplished				