MetLife

PHYSICIANS STATEMENT FOR ACCIDENT

To be completed by the phycisian.

Name of Patient : …… Date of Birth : ……..……..
Occupation: ……..……Identity Card Number: ……

1. Date of Accident: ……..
1α. Date of visits:
First Time: …….. Last time: …….. Total number of visits ……
Has patient been examined by any other doctor? YES ☐ NO ☐
If yes, by whom and when? ……..……..……
2. α) What has been the cause of the accident from what you are aware ……
……..
……..……..……..……
b)) Have you observed any signs of bodily injury that have been conclusive of an accidental injury? YES ☐ NO ☐
If yes, describe: ……..……..……
……..……..……
c) Any other clinical findings?: ……..……..……
……..……..……
d) Diagnosis and X-Ray findings (in detail) : ..……..……
……..……..……
e) Treatment performed or recommended……..……..……
……..……..……
3. a) The symptoms of the patient have been solely from the accidental injury and have been sustained totally and directly as a result of the specific injury? YES ☐ NO ☐
If no, describe : ……..……..……
b) Has insured been hospitalized for similar incident YES ☐ NO ☐
If yes, give details : ……..……..……..
4. The patient been hospitalized in a clinic or hospital; From: …….. To : …….
5. Have you given a sick leave period From: …….. To : …….
6. During the period of the granted sick leave
a) The patient was able to supervise his work or work partially : From : …….. To : …….
b) The patient was totally disable to perform his occupation or perform supervision From : …… To :……....
d) When do you expect that he will be able to return back to his occupation ?……..
7. Has the patient recovered YES ☐ NO ☐
If not, please describe his present medical condition: ……..……..
……..……..……..……
8. In case of long period to recover, when do you expect that he will be back to work: ……..
……..……..……..……

To the best of my knowledge and belief above statements are true and accurate.
Signature of Attending Physician & Seal……
Full name of Attending Physician ……Date: ……..

Policy Number : ……..…….. Signature of Insured. ……..…… **CL4B**


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