BDO life®

Attending Physician's Statement - Accident Claim

This form must be completed by a qualified and registered physician. Costs, if any, shall be shouldered by the claimant.

1. PATIENT'S INFORMATION

a. Name : _____
Last Name First Name Middle Name

b. Address : _____

c. Date of Birth : _____ Place of Birth : _____ Age: _____ Status: _____

2. CONSULTATION FOR CURRENT INJURIES

a. Date of first consultation _____ Patient's Complaint(s) _____

_____

b. Date and Time of Accident_____ Place of the Accident _____

c. Please narrate how the patient's injuries were sustained. _____

_____

_____

d. Please describe the patient's injuries. _____

_____

_____

e. If Surgical Procedure was performed, please narrate in detail the procedure(s) and provide a copy of the Operation Room Record and Pathology Report .

_____

_____

f. Assessment of the patient's condition. (Please provide complications/results of treatment of the injury(ies), etc.)

_____

_____

g. Final Diagnosis/ses and Prognosis/ses _____

_____

_____

I hereby certify that the above statements are true, correct and complete to the best of my knowledge and according to records in my possession, if any.

Executed at _____ this _____ day of _____20_____.

_____	_____
Signature Over Printed Name of Physician	Specialty
_____	_____
Address	Contact Number (s)
_____	_____
PRC Number	PTR Number