

ACCIDENT - STATEMENT OF MEDICAL EXAMINER

SECTION B

1. Section B of this form is to be completed by a legally qualified and registered medical practitioner who has treated the Participant for the injuries sustained.

Cor	ntract / Policy No: .								
1.	Name of Patient:								
2.	2. NRIC No. :								
3.	Occupation as indicat	ed to you :							
4.	Date of Accident :						(am/pm)		
5.	Date of <u>first</u> consultati	ion with you:	(dd/mm	n/yyyy) Tim	ne :		(am/pm)		
6.	Describe in detail the nature of accident as related to you by the patient:								
7.	7. Were there any external and visible injuries or wound as a result of this accident? Yes No i. If yes, please describe the extent of injuries including site and other characteristics, features as seen by you.								
	ii. If no, please describe any other evidence that is consistent with the accident as claimed by the patient.								
8.	8. Treatment given including follow up visits (eg: number of stitches, types of dressing, surgical operations, etc)								
	Date of consultation (dd/mm/yyyy)		Treatment given		Healing Progress				
	. , ,,,,,								
9. Was the patient referred to you by other doctor?									
	Name of Hospital	Date of Admission (dd/mm/yyyy)	Date of Discharge (dd/mm/yyyy)		of Surgery formed	Date of Surgery (dd/mm/yyyy)	Other Diagnosis Procedures or Treatment		
11	11. Stitches removed on:								
	12. Date of commencement of medical leaves :								
	13. Date of expiry of medical leaves :(dd/mm/yyyy)								
	14. Number of days of light duty:								

15. Date of full weight bearing	(dd/mm/yyyy)						
16. Was the patient under the influence of intoxicating liquor, drug or narcotic a	at the time of accident?						
17. Was the healing complicated, eg: infection, malunion etc?	□ No						
i. If yes, please give details of complications							
18. Did the patient suffer any amputation of limbs? \square Yes \square No							
i. If yes, please stated level of amputation seen (proximal, middle, distal)							
19. Last date of consultation :							
20. Did the patient suffer any loss of eyes?							
i. Please give details on patient's Visual Acuity as at last consultation; (a) Right eye:(b) Left eye:							
21. Condition of healing / recovery of the injury as at last consultation date							
22. Does the patient suffer any limitation of movement on any joint as at last consultation date? Yes No i. If yes, please state the limitation and range of movement							
23. Does the patient suffer any loss of use of limbs or /and fingers as at last consultation date?							
If yes, please state the power of patient's upper and lower limbs as at last consultation date.							
i. Right Upper Limb :	i. Right Upper Limb :						
ii. Left Upper Limb : Left Lower Li	imb :						
24. Was there any physical defect, illness or medical history which may have contributed to the accident and/or prolonged the disability?							
25. Does the patient suffer from any permanent disablement or physical defect as a result of this accident?							
	i. If yes, please describe						
26. If the patient was diagnosed to have High Blood Pressure and / or Diabete taken on him / her starting from the <u>first</u> recording done:	s, please state the recorded blood pressure or diabetes						
· — ·	e (dd/mm/yyyy) Results for Blood Glucose (Fasting)						
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DECLARATION							
hereby declare that the foregoing answers and statements are complete and tru withheld no material fact from the Company. I also hereby certify that the above clinic.	ue to the best of my knowledge and belief and that I have e information is correct as per record from the hospital /						
Signature of Doctor :							
Name of Doctor :	Qualification :						
Felephone No. :	Fax No. :						
Date :(dd/mm/yyyy)							
Official Stamp of Doctor :	Name and Address of Clinic / Hospital Official Stamp						
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