ALLIANZ GENERAL INSURANCE COMPANY (MALAYSIA) BERHAD

PART II - CERTIFICATE OF MEDICAL ATTENDANCE

No claim can be admitted unless this Medical Report from a duly qualified and registered Medical Practitioner is furnished to the Company at the Insured's own expense.

Policy No : .....

Claim No : .....

Name: NRIC No:	(Please complete in words)
Petient's Ref No:	Date of Accident:
Age: Sex (Male / Female):	Time of Accident:
Occupation:	Date Consulted:
1. (a) Describle in detail the nature of accident as related to you by the patient	(a)
(b) Describle in detail the nature of illness.	(b)
Is the condition due to pregnancy? If yes, state date pregnancy commenced.	☐ Yes ☐ No
2. (a) Were there any external and visible injuries seen as a result of this accident?	(a) ☐ Yes ☐ No
(b) If yes, describe the extent of injuries including site and other characteristic features as seen by you.	(b)
(c) Are the injuries consistent with the circumstances of the accident as described to you?	(c) ☐ Yes ☐ No

3. Treatment given including follow-up (such as number of stitches, physiotherapy, type of dressing, etc).

Date(s) in words	Time (am/pm)	Treatment

Stitches were removed on : _____

4. (a) Are you the patient's regular medical attendant?	(a) ☐ Yes ☐ No
(b) How long have you known the patient?	(b)
(c) To your knowledge, was the patient suffering from any disease or physical deformity at time of accident?	(c) ☐ Yes ☐ No

5. Names and addresses of other physicians who treated patient for the same injury:

Name	Address	Approximate Dates

6. If the patient was put on a P. O. P./Backslab or immobilized, kindly include the following information :

(a) Date the P. O. P. /Backslab was applied — (a)
(b) Date P. O. P. was removed — (b)
(c) Date patient was started on physiotherapy — (c)
(d) Date patient was started on full weight bearing exercise (if any) — (d)
(e) Was there any limitation of movement on any joint at the last day of treatment? If so, please give details. — (e) ☐ Yes ☐ No

7. Did the injuries require any of the following:

(a) Hospitalisation — (a) ☐ Yes ☐ No — Name of Hospital _____ Date Admitted _____ Date Discharged _____

(b) X-ray — (b) ☐ Yes ☐ No — X-ray report _____

(c) Special diagnostic procedure or treatment — (c) ☐ Yes ☐ No — Type of procedure / treatment _____

(d) Surgery — (d) ☐ Yes ☐ No — Type of surgery performed _____

8. Bearing in mind the patient's occupation as stated above, do you feel that the injuries would have prevented him/her from working from the date of the accident? ☐ Yes ☐ No

9. If your answer to the above is 'yes' and absence from work of more than 2 weeks was necessary, please describe in detail the reasons why you feel that the patient could not return to work earlier keeping in mind the occupation of the patient.

10. Give details of any circumstances, such as, intoxication, physical defects or medical history which may have contributed to the accident and/ or lengthen the disability.

I hereby certify that I have personally examined and treated the patient for his/her injuries described above and that the facts as stated above represent my medical opinion of his/her condition.

Signature of Attending Physician : _____ Qualification : _____

Name & Address : _____ Tel No : _____
(Official Stamp)

For purpose of identification the patient must sign his name below in the presence of the Physician.

Signature of Patient : _____ IC NO. _____ Date : _____

AZHP05/15