ASKARI LIFE ASSURANCE COMPANY LIMITED

PHYSICIAN STATEMENT

Policy No. _____ Claim No._____

1. a) Name in full (block letters)
   b) Father's/Husband's Name
   c) Residential address at the time of accident
   d) Business address (if more than one state all)
   e) Present age, height & weight

2. a) Date of accident
   b) Time and Place of accident
   c) Exact cause of accident and injuries sustained.

3. a) If fracture or dislocation, state whether Complete ☐ or Incomplete ☐
   b) If fracture of long bones, state whether through Shaft ☐ or Extremity ☐
   c) Was it confirmed by X-ray? Yes ☐ No ☐

4. a) When did patient first consult you for this condition?
   b) Described any other disease or infirmity affecting present condition.

5. a) If surgical operation performed, describe fully:

6. a) State the total number of days the patient necessarily and entirely confined to bed, room or house, as the sole and direct result of the injuries sustained.

To Bed	To Home	To Office
From_____	From_____	From _____
To _____	To _____	To _____

7. a) If patient still confined to any, state condition.
   b) Name & address of hospital.
   c) If discharge, give date:

8. a) How long was or will patient be continuously totally disabled?
   From: _____ To:_____

9. a) How long was or will patient be partially disabled?
   From: _____ To:_____

I hereby certify that my answers to the foregoing questions are correct & true, to the best of my knowledge and belief, without evasion or reservation.

Date:_____ Signed & Stamp _____

Attending Physician