Form B

MEDICAL CERTIFICATE

I HEREBY CERTIFY that I have personally examined the injuries sustained by the insured person in the accident described herein, and that the said injuries are as follows:

1. Nature and extent of injuries: _____

_____

2. Final Diagnosis: _____

_____

3. Is the patient now, or was he at the time of the Accident, subject to or suffering from any illness or disease irrespective of the injury? _____

_____

4. Is there any connection between the present disablement and any disease or previous accident? ☐ Yes ☐ No

If so, please give details: _____

_____

5. Is surgical interference necessary or likely to become so? ☐ Yes ☐ No

Please explain briefly. _____

_____

6. What was your medical management? _____

7. Has the patient been confined to the house by your instructions? ☐ Yes ☐ No

If so, state incusive dates. From: _____ To: _____

8. Please state the date when the patient can resume.

Light work Date: _____ His usual occupation Date: _____

9. When did the patient first consult you for this condition? Date: _____

TEMPORARY TOTAL DISABLEMENT

I FURTHER CERTIFY that insured has been wholly unable to leave his ("Bed", "Bedroom", "House") and he has been totally disabled by the above Accident Injuries from the _____day of _____, _____, and that he is likely to be disabled for _____ from the present time.

TEMPORARY PARTIAL DISABLEMENT

I FURTHER CERTIFY that insured has been partially disabled by the above Accidental Injuries from the _____day of _____, _____, and he/she is likely to be disabled from _____ to the present time.

Date: _____

Name and Signature of attending physician: _____

_____

Address: _____

_____

Temporary total disablement - payable when an insured is totally disabled temporarily from engaging in or giving attention to profession or occupation.

Temporary partial disablement - payable when an insured is able to attend to some extent of his profession thereof or occupation but unable to attend to a substanial part.

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