PHYSICIAN'S STATEMENT

Please complete this form and return to patient. Patient's accident claim cannot be processed without the completed Physician Statement

Name of Patient ______________________________

Date of Birth (mm/dd/yyyy) ______________ Male / Female ______________

Mailing Address including City and Postal Code ______________________________
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Date of first visit ______________________________

Complete description of the injury and your diagnosis
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If hospital was required, give name of facility ______________________________

Date admitted______________________ Discharge date ______________

Name of referring physician, if any ______________________________

Physician Name ______________________________

Signature ______________________________

Address ______________________________

Date ______________