

This form must be completed by a qualified and registered physician. Costs, if any, shall be shouldered by the claimant.

1. PATIENT'S INFORMATION

- a. Name : _____
Last Name First Name Middle Name
- b. Address : _____
- c. Date of Birth : _____ Place of Birth : _____ Age: _____ Status: _____

2. CONSULTATION FOR CURRENT INJURIES

- a. Date of first consultation _____
Patient's Complaint(s) _____
- b. Date and Time of Accident _____ Place of the Accident _____
- c. Please narrate how the patient's injuries were sustained.

- d. Please describe the patient's injuries.

- e. If Surgical Procedure was performed, please narrate in detail the procedure(s) and provide a copy of the Operation Room Record and Pathology Report .

- f. Assessment of the patient's condition. (Please provide complications/results of treatment of the injury(ies), etc.)

- g. Final Diagnosis/ses and Prognosis/ses

I hereby certify that the above statements are true, correct and complete to the best of my knowledge and according to records in my possession, if any.

Executed at _____ this _____ day of _____ 20_____.

Signature Over Printed Name
of Physician

Specialty

Address

Contact Number (s)

PRC Number

PTR Number