Note: This section 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. DETAILS OF HOSPITALIZATION

a. Date of first consultation ______________ Patient's complaint(s) ______________________

b. Symptoms experienced ______________________ Date symptoms first experienced ____________

c. Name and Address of Hospital

____

____

d. Inclusive Dates of Confinement: From: __________ To: __________ No. of days at the ICU: ________
(must be supported by hospital bill)

e. Please provide brief history of patient's illness/injury

____

____

____

f. Did the patient consult any other physician/s for this illness/injury before she consulted you? ______ If yes, please provide details below.

Date of Attendance	Name of Physician	Medical Institution and Address	Diagnosis/Treatment/ Procedure

g. If Surgical Procedure was performed, please narrate in detail the procedure and provide a copy of the Operation Room Record and Pathology Report.

____

____

h. Final Diagnosis/ses/Prognosis/ses

____

____

____

BDO Life Assurance Company, Inc.
30th Floor Petron Megaplaza Building, 358 Gil Puyat Avenue, Makati City, Metro Manila
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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