Doctors Certificate (CL 3)

Form No. 3

Contract No. .....

This statement is to be completed by the doctor in attendance during the deceased's last illness or injury and each question should be fully answered.

1- Full Name of client : ..... ID type and Number: .....

Occupations and daily duties .....

Date of proving / deciding Disability .....

Place of declared disability (if Hospital or Institution, give name) .....

2- Cause of disability (Enter only one cause for each of a, b and c)

Disease or condition directly leading to disability (this does not mean the mode of disability such as heart failure, stroke, etc. It means the disease, injury or complication which caused disability.)

a) .....

Antecedent causes (morbid Conditions, if any, giving rise to the above cause (a) stating the underlying cause last.)

b) Due to (or as a consequence of) .....

c) Due to (or as a consequence of) .....

Interval Between onset and disability

a) .....

b) .....

c) .....

Other significant conditions (Contributing to the disability but not related to the disease or condition causing disability)

(Please state past medical history and dates of onset of this medical history)

.....

3. Dates of First and last attendance in last illness .....

How long had you known client named above? .....

4- If disability was due to accident, suicide or homicide, specify which (Describe briefly)

.....

5- Is client completely disabled ? ☐ YES.. ☐ NO

If No , please state percentage of disability and expected duration .....

If so, by whom and with what findings? .....

.....

6- Have you treated the patient during the last 5 years prior to last Disability? ☐ YES.. ☐ NO

Did the Patient , to your knowledge, receive treatment during the last 5 years from Any other physician, or in any hospital or Institution? ☐ YES.. ☐ NO

If "Yes" to either question, please furnish the following:

Physician or Hospital	Address	Nature of Illness or Injury	Dates

Date :

Signature and stamp of clinic :

Address :