TAKAFUL PAKISTAN LIMITED

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PERSONAL ACCIDENT

MEDICAL REPORT

(The form to be completed by Claimant's Medical Attendant whose replies should be as full as possible)

Policy Number:		Expiry Date:	D	D	M	M	Y	Y	Y	Y

Name of Claimant:	
The nature and extent of injuries: (if to a limb, state whether right or left)	
The cause of the accident so far as known to you: (Please use separate sheet if required)	
a) Date of your first attendance upon him in consequence of the injuries sustained. b) Are you still in attendance?	a) b)
Are you his usual medical attendant? And if so, how long have you known him, and for what have you attended him?	
a) Are his symptoms (i) due exclusively to the accident, or (ii) traceable to disease infirmity or any other cause? b) Has he ever suffered from Gout, Rheumatism, Diabetes or Fits? c) Is there anything in his medical history which may have contributed, directly or indirectly, to the accident, or which may be likely to retard his recovery? d) Have you any reason to suppose that he was under the influence of intoxicants at the time of the accidents?	a) b) c) d)

State the time, within your own knowledge that the claimant has been, as the direct and sole consequence of the injuries sustained, necessarily confined to his bed, if still so confined, state to which: and the probable duration of confinement to each.	**To Bed** Both days inclusive									**To House** Both days inclusive								
	From	D	D	M	M	Y	Y	Y	Y	From	D	D	M	M	Y	Y	Y	Y
	To	D	D	M	M	Y	Y	Y	Y	To	D	D	M	M	Y	Y	Y	Y

a) Has he been able to attend to any portion of his business or occupation? b) If so, from what date? c) If not, please state probable date. i) of his being so able ii) of his complete recovery(ies)	a) b) c) i) ii)

Is there now any disability? If not, please give date of recovery:	

Any further remarks:	

I hereby certify that the above-named with the accident referred to, and that the foregoing statements are correct.

Name of Doctor: ______________________ Hospital/Clinic ______________________

Signature: ______________________ Qualification ______________________

Address: ____

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Date:	D	D	M	M	Y	Y	Y	Y

TOTAL DISABLEMENT occurs when the Participant is wholly prevented from attending to his business or occupation.

PARTIAL DISABLEMENT when prevented from attending to a substantial portion thereof.