

Attending Physician's Statement (Death Claim)

1. General Information	Name of Physician			
	Address			
	Mobile No.		Email Address	
2. Declarations	Full Name of Deceased			
	Address at Death			
	Age at Death		Date of Death	
	Place of Death (Give Name of Hospital/Clinic)			
	Cause of Death			
	a. Disease or condition directly leading to death _____			
	b. Antecedent Causes (Morbid conditions, if any giving the rise to the above cause) Due to _____			
	c. Other significant conditions: (contributing to the death but not related to the disease or condition causing death)			
	d. If death was due to accident, suicide or homicide, please specify and describe briefly			
	How long have you known the deceased?			
	What were the symptoms first noticed by deceased?			
	What was your diagnosis?			
	In your opinion, how long did the deceased suffered from his ailment?			
	Did you inform the deceased of your diagnosis?			
	OTHER PHYSICIANS TO YOUR KNOWLEDGE WHO ATTENDED THE DECEASED FOR ANY ILLNESS:			
Name		Address	Date	Reason/Treatment
PLEASE STATE NAME OF OTHER HOSPITALS/CLINICS TO YOUR KNOWLEDGE THE DECEASED WAS TREATED FOR ILLNESS OR INJURY:				
Hospital/Clinic		City/Town	Date	Diagnosis
As far as you know, was autopsy performed? If so, please provide details:				
3. Signatures	Date Signed		Place Signed	
	Name of Physician		PTR	Signature X
	Name of Witness			Signature X

NOTE
Please use reverse side of this form if space provided is not enough.