DOCTOR'S CERTIFICATE FOR ACCIDENTAL DISABILITY

POLICY NUMBER								

Date: DD/MM/YYYY

Personal details of the Patient (Life Assured):

- Full Name of Patient: _____
- Date of Birth: DD/MM/YYYY

Clinical Manifestation:

- Date of first Diagnosis: DD/MM/YYYY
- Duration since it is Diagnosed: _____Years _____Months _____Days
- Progress of Patient: _____
- Stimulating Factors: _____
- Any history of same illness: - ☐ *YES ☐ NO *If yes please provide the treatment records

Medical History:

Tick if Yes	Factors	Comments
	Hypertension	
	Diabetes	
	Dyslipidaemia	
	TIA/Stroke	
	Heart Disease	
	Valvular/AF/Ischaemic	
	Peripheral vascular disease	
	Carotid Bruit (due to Carotid Artery Stenosis or Atheroma)	
	Smoking	
	Deep Vein Thrombosis	
	Any other condition	

Details of Disability:

Sr.	Symptom	Status		Comments
1.	Total and irrecoverable loss of sight of both eyes	Y	N	
2.	Amputation or loss of use, of both hands at or above the wrists	Y	N	
3.	Amputation or loss of use, of both feet at or above the ankles	Y	N	
4.	Amputation or loss of use, of one hand at or above the wrist and one foot at or above the ankle	Y	N	

Course of Treatment:

- Is there any current neurological deficit ☐ *Yes ☐ No: *If yes please mention the same in detail
- Is there any improvement in the neurological deficit from the date of diagnosis? ☐ *Yes ☐ No
  *If yes, how would you rate the improvement, if asked in percentages - _____%
- Can the patient perform below mentioned activities of daily living comfortably?

Tick if Yes	Activities	Comments
	Mobility	
	The ability to move indoors from room to room on level surfaces	
	Transferring	
	The ability to move from a bed to an upright chair or wheelchair and vice versa	
	Dressing	
	The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances	
	Washing	
	The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means	
	Feeding	
	The ability to feed oneself once food has been prepared and made available	
	Toileting	
	The ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene	

- Can patient perform any of the above-mentioned daily activity with aid of mechanical equipment, special device, or any other aid:
  ☐ *Yes ☐ No

  If yes, kindly specify the aid:_____

Prognostication:

Declaration

The above statements are true and complete to the best of my knowledge and belief and as per the records maintained by me/hospital/clinic:

Name of the Doctor		**Signature of the Doctor**	**Doctor/Hospital seal**
Qualification of the Doctor			
Regd.no. of the Doctor			
Contact no. of the Doctor			
Email id of the Doctor			
Date			