Sun Life GREPA Financial

For the Attending Physician

THIS IS TO CERTIFY that the following appears in our Hospital Records:

Full Name of Patient _____ Date of Birth _____ Age ____Gender _____ Civil Status _____

Date Admitted _____Time Admitted_____ Date Discharged _____

Was Patient a registered bed patient? Yes ☐ No ☐ Patient was hospitalized in a ☐ Ward ☐ Semi-private ☐ Private ☐ ICU

Hospital Case Number _____ Hospitalization was recommended by _____

Name of Attending Physician _____ License No. _____

Address of Attending Physician _____ Tel. No. _____

Diagnosis of sickness or extent of Injury _____

What are the complaints or physical findings? _____

What is the History of the Illness? _____
_____
_____

Date of first Signs and Symptoms _____

Description of Signs and Symptoms: _____
_____

Are you the Physician whom the patient initially consulted regarding this illness? Yes ☐ No ☐
If NO, please give the name of the Physician_____ Address/ Hospital _____ Contact No._____

Consultation done _____
Date of 1st consultation _____

Did the Patient have any signs / symptoms prior to consulting you? Yes ☐ No ☐
If YES, please specify date signs / symptoms first started _____

Please specify approximate date of discovery of the Sickness / Injury _____

Diagnosis made by Attending Physician_____

Is condition a nervous / mental disorder? Yes ☐ No ☐

Is condition a congenital anomaly or physical defect present at and existing from the time of birth regardless of the time of discovery or treatment? Yes ☐ No ☐

Is condition connected with pregnancy, infertility, childbirth, and gynecological problem? Yes ☐ No ☐

Has Patient ever had same or similar condition? Yes ☐ No ☐ Not to my knowledge ☐ If YES, please give details:

Date	Name of Physician / Surgeon	Name of Hospital	Diagnosis
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please indicate the nature of the Life Insured's medical condition. Curable ☐ Non- curable ☐

With reasonable medical certainty, will the medical condition of the Life Insured result to death in 12 months or less ☐ more than 12 months? ☐

Is the medical condition of the Life Insured a result of any form of self-inflicted injury? Yes ☐ No ☐

Dated at _____this _____ day of _____, 20__

_____
Signature over Printed Name of Attending Physician

_____
Hospital

_____
Hospital's Com

Please return this form to the Life Insured