FORM B2

CERTIFICATE OF TREATMENT

Form No. 3816 A

In connection with claim under Policy No. _____

_____on the life of

_____(Mention full name of the deceased)

1. What was the full name, age, address, and occupation of the patient as per your records?

Name :
Age :
Address :
Occupation :
Father s / Husband s name :

2. What was the date of his first consultation with you for the ailment referred to and when your treatment commenced? -

3. Under whose treatment was the patient, before you were consulted? -
If the patient has brought a letter of a note from any doctor at the time of consultation, kindly furnish us with a certified copy thereof -

4. What at the time of consultation, was :
a) The nature of his complaint ? -
b) The duration of complaint as reported by him ? -
c) Exact History of the patients ailments at the time of consultation ? -

5. What as you could judge, was the duration of his complaint? -

6. What was the diagnosis arrived at by you? -

7. Was there any other disease or illness which preceded or co-existed with the ailment at the time of his consultation with you? -
If so, what was it?
Please give history of such disease or illness stating :

a) Dates when first observed by the patient? -

b) By when treated -

c) By when history was reported to you -

8. What was the date on which you last attended him and his condition then? -

9. Was he treated by you on any previous occasion or any later occasion? -
If so, Please state
a) Date on which treatment commenced -

b) Date last attended b y you and his condition then -

c) Nature of ailment? -

10. Are you maintaining records of all patients treated by you and whether the above information has been noted from such records? -

CERTIFIED THAT THE ABOVE INFORMATION IS CORRECT
AS PER RECORDS MAINTAINED BY ME

Signature :

Date :

Code No.

Qualification &
Designation :

Witness :

Signature :

Designation :

Address :