ATTENDING PHYSICIAN STATEMENT

This form must be completed in full

Patient's Name:_____ Date of Birth:_____

Diagnosis_____ ICD Code(s)_____

What date did illness commence / injury occur?_____ Date 1st seen for this complaint_____

Has the patient had treatment for the same or related condition before? ☐ Yes ☐ No

If yes, please list all dates of treatment:_____

Date(s) of any hospitalization from _____ through _____

from _____ through _____

Date(s) & list of any surgical procedures performed_____

_____

Medications prescribed:_____

Name of any referring physician:_____ When referred?_____

List of any known physician's treating this patient:

Name:_____ Phone:_____

Name:_____ Phone:_____

Name:_____ Phone:_____

If patient is the traveler, did this condition disable him/her from travel ☐ Yes ☐ No

Include dates of disability from _____ through _____

If patient is a non-traveling family member, please indicate dates the family member's care / attendance were required:

from _____ through _____

Physician's Name (printed)_____ **T.I.N.**_____

Physician's Signature:_____ **Date:**_____

Address_____ **Telephone Number**_____

_____ **Fax Number**_____

_____