TOTAL AND PERMANENT DISABILITY INSTALMENT BENEFIT - DOCTOR'S STATEMENT

Note: This form is to be completed at the Patient's expense by the Attending Physician/Surgeon who treated the patient.

PRUDENTIAL

Patient's Personal Details

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SECTION A : Medical Record of the Patient

м. Please describe the full and exact diagnosis and diagnosis date.

2. With the current health condition of the patient, what would you evaluate the current working capacity of the patient?

Please select [✓] one of relevant option.		Description for the condition
	Incapable of light manual duties. (I.e. slight restriction on mobility)	
	Incapable of heavy manual duties without restrictions. (I.e. moderate restriction on mobility)	
	Incapable of sedentary manual duties. (I.e. severe restriction on mobility)	

3. Please provide the details of the patient's ability to perform an occupation.

	Own Occupation	Other Occupation
a. Is the patient now totally disabled?	☐ YES ☐ NO	☐ YES ☐ NO
b. (i) Do you expect a fundamental or marked change of this present condition in the future?	☐ YES ☐ NO	☐ YES ☐ NO
(ii) If Yes, when do you consider the patient will be able to resume work?		

SECTION B : Attending Doctor's Declaration

I hereby certify that:

☐ I am the patient's attending doctor and I have personally examined and treated the patient for the illnesses/ injuries sustained; OR

☐ I have personally perused the patient's medical records;

and that the facts as stated above are all true to the best of my knowledge and information that I have perused.

Signature :

Date :

Name :

Professional Qualification :

MMC/ Registration Number :

Name & Address of Hospital/ Clinic :

Official Stamp of the Doctor :

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