BERKSHIRE HATHAWAY SPECIALTY INSURANCE

# Accident & Health

GENERAL PHYSICIAN CLAIM FORM

## CERTIFICATE OF ATTENDING PHYSICIAN

***To be completed by attending physician.***
The claimant must obtain, at his/her own expense, the completion of this certificate from a duly qualified and registered medical practitioner. In the event of the medical practitioner being unable to answer from their own personal knowledge any of the following questions, they are requested to state so.
Furnished in connection with the disability of:

Name of Patient: _____

Full Address: _____

Are you the patient's regular physician? ☐ Yes ☐ No

*If yes, how long have you known the patient? (years & months)*

_____

Has the patient previously suffered from the same or similar injuries/sicknesses? ☐ Yes ☐ No

*If yes, provide the date and diagnosis:*

Date of first consultation of this condition: _____

In your opinion, how long has this condition been in existence whether treated for same or not?

Present Condition:

Prognosis:

Nature of operation (if any):

Name of physician(s) who previously treated patient for the above condition:

Are the patient's symptoms:

*Due exclusively to the accident*? ☐ Yes ☐ No

*Traceable to disease?* ☐ Yes ☐ No

*Infirmity or any other cause?* ☐ Yes ☐ No

Is there anything in the patient's medical history which may have contributed, directly or indirect, to the injury/illness or which may be likely to retard the patients recovery? ☐ Yes ☐ No

*If yes, please provide details:*

Is the patient still under your care for this condition? ☐ Yes ☐ No

*If no, on what date did you release the patient to perform regular duties?*

_____

Dates unfit for work, or unable to perform specific parts of the patient's occupation?
*(if uncertain please estimate)*

_____

Have you any reason to suppose that the patient was under the influence of intoxicants or drugs at the time of the accident? ☐ Yes ☐ No

If hospitalised, please provide dates: _____

Name of hospital: _____

Dates patient was totally disabled: _____

In your opinion, probable further disability should not exceed past the following date:

_____

Name of Physician: _____

Full Address: _____

Office Phone Number: _____ Mobile Phone Number: _____

Qualifications:

_____ _____

Signature of Physician Date