

CERTIFICATE OF ATTENDING PHYSICIAN

1. a) Deceased's Name in Full: _____
 c) Residence at time of death _____
 d) Occupation at time of death _____ e) Prior thereto _____
 f) Age of the deceased at death _____ g) Sex _____ h) Height _____ i) Approximate Weight in health _____
 j) Were there any identification marks on the body? _____ k) If "Yes", give particulars _____

2. a) Date of Death _____ b) Place of Death _____
 c) If in hospital or institution, give name _____

3. a) Do you know the deceased personally? _____ b) How long have you known the deceased? _____
 c) When were you first consulted by the deceased, for the condition which either directly or indirectly caused death? _____
 d) Are you his regular physician _____ e) What was your diagnosis then _____
 f) What treatments did you give to the deceased?
 Medication _____ Date started _____
 Surgery _____ Date performed _____
 Therapy _____ Date started _____
 Other treatment? _____ Date started _____

g) Date when deceased was first made aware of the diagnosis? _____

h) Give below particular of each condition for which you treated or advised deceased prior to last illness:

Nature of Condition	Date	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

i) Aside from the above, was the deceased suffered from other disease/illness for the last 5 years?

Disease/Illness	Since when	Source of Information
_____	_____	_____
_____	_____	_____
_____	_____	_____

What treatments were given? _____

4. a) What was the immediate cause of death? (See Instruction on the reverse side) _____
 b) How long did the deceased suffer from this disease or impairment? _____
 c) For how long before death was the deceased confined to house or prevented from attending to business? _____
 d) For how long was the deceased bed-ridden? _____
 e) What were the contributory causes of death? Give below, as nearly as you can by dates, the duration of each

Disease or impairment	Duration
_____	_____
_____	_____
_____	_____

F) Was death due to suicide, homicide, or accident? _____

G) Was deceased use alcohol or narcotics? If yes, did they contribute to his death? _____

H) Was there any special connection (remote or proximate) between the death and the occupation, residence, habits or personal history of the deceased? If yes, please give particulars _____



5. Give names and addresses of all other physicians and other practitioners who, to your knowledge, attended deceased during the past three years?

Name	Address	Disease or Impairment & Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Was there an official inquiry as to cause of death or a post-mortem examination on the body of the deceased? _____ If yes, by whom and with what was the result? _____

I _____ hereby certify that the answers given are full, complete and true. I am a graduate of
(Printed name of Physician)
_____ in _____
(Medical College)

AUTHORIZATION

This authorizes the MANILA BANKERS LIFE AND GENERAL ASSURANCE CORP. or its authorized representative to secure clinical/hospital records relative to the subject's illness, sickness or injury. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

Date and signed at _____ on _____

Physician's Signature

PRC No. _____

Date Issued _____

Place Issued _____

Full address of Physician

INSTRUCTIONS

All Answers Must be Entirely in the Physician's Own Handwriting

In the interest of accurate vital statistics, please conform to the International List of the causes of death when answering Question 4.

If an injury, describe the accident. If a suicide or homicide, state the means employed.

In surgical cases, state the nature of operation and the disease or condition requiring such procedure. In females, puerperal states are to be indicated. In neoplasm, give type and part first involved. Please avoid indefinite terms. Describe any unusual features.

Where spaces provided for the answers are too small, such details as seem desirable should be given below.

