TIP Friendly Society
80 Half Way Tree Road, Kingston 10
Tel: (876) 920-8399, (876) 960-0729
Toll Free: 1-888-991-4189

ATTENDING PHYSICIAN/SURGEON STATEMENT

THE INSURED IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE SOCIETY

Patient's Name: _____ **Date of Birth:** _____

Please give complete diagnosis of this condition (if injury involved eye or limb, state whether right or left. If fracture or dislocation occurred, state which and whether compound, complete or incomplete. If fracture or long bones occurred, state whether through head or shaft):

_____

_____

INJURY/SICKNESS

1. When did present injury occur or illness began? _____
2. If accidental injury, give details of accident: _____
3. Was the patient at the time of this accident or during this disability affected with any previous injury or any other diseases?
   ☐ Yes ☐ No If yes, please provide details _____
4. To your knowledge, did he have any infirmity or physical impairment prior to this accident, or disability? ☐ Yes ☐ No

HISTORY

5. When did this patient first receive medical treatment? Date _____ / _____ / _____
6. Is there a previous history of this or a similar condition? ☐ Yes ☐ No
7. If yes, please provide details _____
8. How long have you known the patient? _____
9. Are you the regular General Practitioner? ☐ Yes ☐ No
10. If no, please advise who is _____

DEGREE OF DISABILITY

11. When was the patient obliged to cease work? _____
12. When will the patient be able to return to: Partial duties _____ / _____ / _____ **OR** Full duties _____ / _____ / _____

TREATMENT OF PRESENT CONDITION

13. When were you consulted? Initially _____ / _____ / _____ Most Recently _____ / _____ / _____
14. Was patient confined to hospital? ☐ Yes ☐ No Period of Confinement ____ / ____ / _____ To ____ / ____ / _____
15. If yes, please advise Name & Address of Hospital: _____
16. Was an operation performed? ☐ Yes ☐ No If yes, please provide date of operation and details: _____
17. Was patient confined at home? ☐ Yes ☐ No Period of Confinement _____ / _____ / _____ To ____ / ____ / _____
18. Was patient confined to a bed? ☐ Yes ☐ No Period of Confinement _____ / _____ / _____ To ____ / ____ / _____
19. Was patient ambulatory? ☐ Yes ☐ No Period of Confinement _____ / _____ / _____ To ____ / ____ / _____
20. Are there any underlying conditions affecting recovery from the current conditions? ☐ Yes ☐ No
21. If yes, please advise the nature of underlying conditions and how they affect disability and recovery _____
22. What is the current prognosis? (Kindly indicate if recovered, improved, unimproved or retrogressed) _____
23. Are there any further remarks, which may assist in assessing this condition? _____

I hereby certify that my answers to the foregoing questions are correct and true to the best of my knowledge and belief.

Date _____ / _____ / _____

_____
Physician's Signature

Physician's Name _____
(PRINT AND STAMP)

Physician's Address _____