THE PHILIPPINE AMERICAN LIFE AND GENERAL INSURANCE COMPANY
Manila, Philippines

CERTIFICATE OF ATTENDING PHYSCIAN

(Accident Claim Form No. 2)

This form should be prepared at insured's expense. Answers to questions should be written on the space after the corresponding question

Name of Patient _____ Occupation _____
Address of patient _____

1. Please state as fully as you can when and how the accident occurred	1. (a) Date of Accident (b) Details of the Accident:
2. When and where did you first see Patient after the accident?	2. (a) Time: [ ]AM [ ]PM Month Day Year (b) Where:
3. Describe fully the nature and extent of the injury(ies) received	3
4. (a) Was he, in your opinion, under the influence of liquor or any intoxicating drink or drug at the time of the accident? (b) If he was, by what means or tests did you arrive at this conclusion? (Please give particulars)	4. (a) (b)
5. (a) How long has the Patient been under your treatment?	5. (a) Duration Month / Day / Year From To
(b) What treatment(s), special examination(s) and/or procedure(s) (e.g. X-ray examination, electtrocardiogram (ECG) analysis, and/or other diagnostic tests) has the Patient had since the accident? If he has any, please give full details, stating the nature of treatment, and/or examination, findings, diagnosis and prescribed regimen.	(b)
(c) Is the Patient still under treatment, what is the reason for this?	(c)
6. (a) Has the Patient ever had, or was he at the time of the accident suffering from any abnormality, disease or illness independently of the injuries sustained? If so, please give full particulars	6. (a) Nature of Abnormality or Illness / Name of Attending Physician / Address / Date (From: M D Y; To: M D Y)
(b) Was the above information given by the Patient himself? If not, from what source was this information obtained, and if this other source be a person, his relationship to the Patient?	(b)
(c) Did the abnormality, disease, or illness (previous or otherwise) contribute to the occurrence of the accident or retard in any way the Patient's recovery from the accident? If so, how and to what extent?	(c)
7. (a) In the absence of any pre-existing abnormality, disease or illness, would the injury or injuries received disable the Patient?	7. (a)
(b) If it would, how long would such a disability last? (Note: (1) Total Disability - unable to do all duties required by the Patient's occupation; (2) Partial Disability - able to do some occupational duties)	(b) Degree of Disability: / Period of Disability (From / To) Total Disability Partial Disability
8. Has the Patient resumed performing his usual ocupational duties? If he has not, when is he expected to do so?	8

I hereby certify that, having personally examined the Patient, the facts as set forth above are true and correct and in my opinion there are no other circumstances (except as mentioned above) tending to prolong disability and prevent Patient from following his usual business or occupation, or to cause the loss defined above.

Dated at_____on the ____day of _____, 200__

_____, M.D.
Signature of Physician over printed name

_____
Signtaure of Witness over printed name

Qualifications _____

Address _____

Address _____

Form No. D-109-2 (0791)