Pak-Qatar Family Takaful Limited

Form DS-2

Disability Claim Form-Physician's Statement

Note :
Please don't leave any blank, unanswered question, date and/or signature, wherever applicable

Patient Information

Name of Patient | Date of Birth

Patient's Address

Employer Information

Name of employer

1. History

(a) Date doctor first consulted due to disability _____ (Day Month Year)

(b) Date symptoms first appeared or accident happened _____ (Day Month Year)

(c) Date patient ceased work because of disability _____ (Day Month Year)

(d) Has patient ever had same or similar condition? ☐ No ☐ Yes, state when and describe

(e) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

(f) Name the first doctor with full address, consulted by the claimant for the above disability/Accident?

Name of Doctor | Address | Mobile No.

2. Diagnosis

(a) Date of Last examination/Consultation _____ (Day Month Year)

(b) Diagnosis (including any complications)

(c) Subjective symptoms

(d) Objective findings (including **current** X-rays, ECG's, laboratory data and any **clinical findings**):
(1). Clinical Findings

(2). Diagnostic studies and results:

3. Progress

(b) Patient is ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

(a) Patient has ☐ Recovered ☐ Improved ☐ Stabilized ☐ Retrogressed

4. Prognosis

(a) Is the disability presumed to be reversible? ☐ Yes ☐ No

(b) Is patient now capable of performing duties of ☐ Yes ☐ No (His or Her Current Jon) ☐ Yes ☐ No (*Any other job for which he or she is reasonably suited or qualified by education, training or experience)

(c) What duties of his or her job is patient incapable of performing?

(d) Do you expect a fundamental or marked change in future? ☐ Yes ☐ No
If "Yes", patient should recover sufficiently to perform duties on or about _____ (Day Month Year)

If "No", please explain

(e) Specify the date by which you presume that the patient will be able to resume his duties/work:
☐ Totally ☐ Partially ☐ Temporarily ☐ Permanently

Remarks

Declaration : I hereby declared that the above statements are true and complete to the best of my knowledge.

Signature	Date
Attending physician's name	Specialty
Address	Telephone No.