Accident Dismemberment Claim - Attending Physician's Statement
意外傷殘賠償 – 醫生報告

Please print in **BLOCK** letters/ 請以**正楷**填寫
(To be completed by the attending Physician at the Claimant's Own Expenses. / 由主診醫生填寫，所需費用由索償人自行承擔。)

Policy No. 保單號碼	Name of Patient 病者姓名	
Occupation 職業	I.D. No. 身份証號碼	Date of Birth 出生日期

1. Medical History / 醫療紀錄

(a) When and How did the accident happen? 意外日期及意外經過?
(a) (/ /)
MM/DD/YY 月/日/年

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(b) When did the patient ceased work because of disability? 病者何時開始因此傷殘而不能工作?
(b) (/ /)
MM/DD/YY 月/日/年

(c) Has the patient ever had same or similar condition? 病者過往有否患上同類或類似之情況?
If 'Yes", please state when and describe/ 若'是',請詳列患病日期及情況。
(c) Yes/是☐ No/否☐

(d) Is condition due to injury arising out of patient's employment? 病者之傷殘是否因其工作而引起?
(d) Yes/是☐ No/否☐

(e) Name(s) and address(es) of other attending Physicians/ **其他**主診醫生姓名**及**地址

Date 日期	Physician's Name or Hospital's Name 醫生姓名或醫院名稱	Address 地址

2. Diagnosis / 診斷

(a) Date of first examination / consultation? 首次檢驗/求診日期?
(a) (/ /)
MM/DD/YY 月/日/年

(b) Date of last examination / consultation? 最後檢驗/求診日期?
(b) (/ /)
MM/DD/YY 月/日/年

(c) Diagnosis (Please state the part of the injured areas) 診斷(請詳述受傷部位)

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(d) Was there any external and visible evidence of injury? If yes, please state the type of injury. 是否有外部及可見之損傷？如是，請詳述其受傷種類。

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(e) Please describe the patient's Present Condition. What are the **degree and range of movement** of the injured areas? 請詳述病者之現時情況 **(包括其受傷部位之移動程度及範圍)**

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3. Dates of Treatment / 治療日期

(a) What kinds of treatment provided 治療種類
(a) ……..

(b) Frequency 就診頻率
(b) Weekly ☐ Monthly ☐ Other(specify) ☐
每週 每月 其它(請說明) …….

(c) The length of each treatment 每次就診需時
(c) ……..

(d) Date of last treatment or scheduled 最後就診日期 (或安排中)
(d) (/ /)
MM/DD/YY 月/日/年

4. Did the patient require having any further operation or continuously treatment? If yes, please give details.
病者是否需要再次進行手術或接受長期治療？如是，請詳述。

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5. Physical Impairment (If applicable) 身體狀況(如適用)

☐ No Limitation of functional capacity; capable of heavy work. No restriction. 無任何功能之限制,可以作體力勞動。無限制。
☐ Capable of medium manual activity. 可作中量之勞動。
☐ Slight limitation of functional capacity; capable of light work. 輕度之功能受限,可作輕度工作。
. ☐ Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity.中度功能受限,可作文書工作。
☐ Severe limitation of functional capacity; incapable of minimal (sedentary) activity. 重度功能受限,不能作任何工作。
☐ Remarks: 其它

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6. Prognosis 預斷病情

(a) Did the injury result in any **Permanent Total Disablement or Total Loss of Use** of the injured areas involved?
(The term "Total Loss of Use" means a total functional disablement which is equivalent to the loss of said limb or organ)
就病者情況，其受傷之肢體是否**永久完全傷殘 或 永久完全喪失功能**?
(喪失功能是指完全失去活動功能，被視作完全喪失該肢體或器官)

Yes/是☐ No/否☐

- If YES, please state the part of permanent total loss of use or disablement. 若是，請詳述永久完全喪失功能或傷殘之位置。

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- If NO, please comment the chance and degree of recovery. 若否，請評論其復原之機會及程度。

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(b) Is the patient recover sufficiently to return to occupation? 病者是否已康復並回復工作? Yes/是☐ No/否☐
If NO, please comment when will the patient resume duty. 若否，請評論病者何時可恢復工作。

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(c) What duties of the patient's job is he/she incapable of performing ? 在病者的工作中,他/她有何種職務不能執行?

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7. According to your opinion, any information will be assisting us in processing this claim? Please specify.
根據閣下的意見，**是否有**其他資料可以協助我們處理是次賠償? 請詳述。

8. Do you consent the FWD Medical Director and/or claim assessor to release the information provided by you in this report to the patient when we are requested by the patient to explain our claim decision?
閣下是否同意當病人有需要時，本公司之醫務人員或賠償批核員可透露閣下所提供之資料，以作解釋有關之賠償決定。

Signature and chop: _____ Date: _____
醫生簽名及蓋章 **日期**

Name of Attending Physician: _____ Qualification: _____
主診醫生姓名 學歷及資格

Address: _____ Telephone No.: _____
地址 電話號碼