

ATTENDING PHYSICIAN'S STATEMENT	Patient's Name _____		Age _____
	Nature of injury (Describe complications, if any) _____ _____		
	Date of accident _____	Nature of surgical procedure, if any (Describe briefly) _____ _____	
	Date performed _____	Where performed _____	If in hospital <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient
	List Non-Surgical Treatments and Dates	Treatment	Date
	List Additional Related Surgical Procedures and Dates	Procedure	Date
If disease, deformity, infirmity or intoxicant was a contributing factor to either the accident or the injury, please state how and to what extent _____ _____			
Have you furnished a similar report to any other insurance companies? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please give names _____			
Is loss of vision irrecoverable? <input type="checkbox"/> Yes <input type="checkbox"/> No Remarks: _____ _____ _____			
Name of Physician (Type or Print) _____			
Signature of Physician _____ Date _____ Telephone _____			
Street Address _____ City _____ State _____ Zip _____			

AUTHORIZATION

TO WHOM IT MAY CONCERN:

I hereby request and authorize you to furnish to the insurance company providing this form, or their representatives, any and all information you may have concerning any illness, or injuries I may have suffered, medical history, consultations, prescriptions or treatments, including x-ray plates, and copies of all hospital or medical reports, that the same may be included as part of the proofs for claim submitted to the company. A photostatic copy of this authorization shall be considered as effective or valid as the original.

(Witness to Insured's Signature)

(Signature of Insured)

Signed this the _____ day of _____, 20_____