

CERTIFICATE OF ATTENDING PHYSICIAN DISMEMBERMENT OR LOSS

Patient's Name: _____

Patient's Address: _____

Policy Number: _____ ID Number: _____

1. (a) When did the accident happen? Month _____ Day _____ Year _____

(b) Briefly describe details of the accident. _____

2. (a) Date of first attendance for present injury. Month _____ Day _____ Year _____

(b) Date of most recent treatment. Month _____ Day _____ Year _____

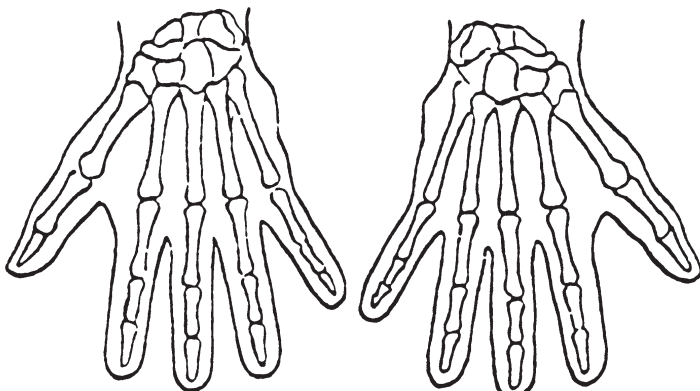
DISMEMBERMENT

3. (a) If the accident caused the loss of hand, foot, leg, arm, fingers, toes, please indicate the specific joint level of the amputation on the diagram below.

- Hand Foot Leg Arm Fingers Toes

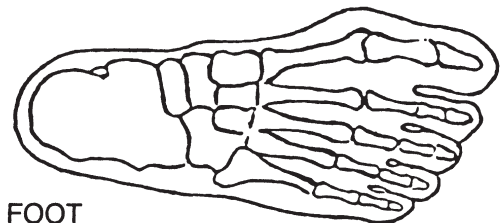
(b) Date of amputation. Month _____ Day _____ Year _____

(c) Please include surgery report and hospital admittance and discharge summary.

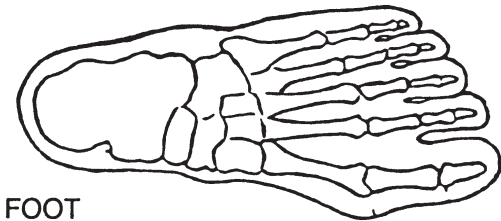


LEFT HAND

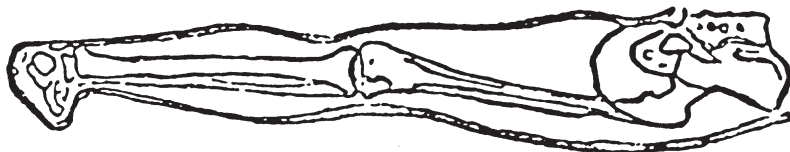
RIGHT HAND



RIGHT FOOT



LEFT FOOT



INDICATE WHETHER RIGHT OR LEFT



4. (a) If the accident caused total and irrecoverable loss of sight, hearing or speech, please indicate which:

Sight Hearing Speech

(b) Date on which loss occurred. Month _____ Day _____ Year _____

(c) Is there any possibility of improvement to the injured area? Yes No

LOSS OF VISION

(a) If known to you, please advise the vision in each eye prior to the accident.

(b) What is the best corrected vision in the affected eye(s), if any?

(c) Please include visual acuity results and Ophthalmologist report.

LOSS OF HEARING

(a) Is there any indication that hearing was abnormal prior to accident?

(b) Level of hearing at date of loss.

(c) Please include Audiologist report and hearing test.

LOSS OF SPEECH

(a) If known to you please advise if the insured was able to speak intelligibly prior to accident.

(b) Is insured's speech intelligible at the present time?

(c) Please include Speech Therapy assessment.

LOSS OF USE

5. (a) If the accident caused loss of use of leg, arm, or hand, please advise which.

Leg Arm Hand

(b) Is there any indication that the injured limb was unable to function normally prior to accident? Yes No

(c) Please indicate what functions, if any, the injured limb is able to perform.

(d) Is there any possibility of improvement to the injured area? Yes No

(e) Please include: Hospital admittance and discharge summary, surgery report (if relevant), Range of Motion test results and Physiotherapist / Occupational Therapist reports, consultation and progress reports, Neurologic exam (paraplegia / quadriplegia).

6. (a) Was the injury described solely responsible for the loss? Yes No

(b) If not, give particulars of any contributing cause or causes.

Print Name _____ Specialty _____ Telephone Number: _____

Date _____ Signed _____ M.D.

Address _____

Street

City

Province

Postal Code
