



Physician's Statement – D2 (for Death Claim)

Note : All answers must be in Physician's handwriting.
Please don't leave any blank, unanswered question, date and/or signature, wherever applicable

1. Deceased's Information

- a. Deceased' Name: Abdul Bazi
- b. Father's Name/Husband's Name: Shehar-ud-Din
- c. Date of Birth of deceased: 1966 Age: 59y CNIC No. 54400-0413500-9
- d. Residential Address: Mohallah Killi Guel Mohammad Muslim
Abad Quetta. Contact No. 0317-8455295

2. Event Information

- a. Date of Death 16/03/25
- b. Place of Death Quetta.
- If died in hospital or other medical institution, please give name Trauma Centre SPH Qta.
- c. Primary Cause of Death Gun Shot Head Causing Major Brain Injury
- d. Secondary Cause of Death Cardio-Pulmonary Arrest.
- e. Interval between onset and death

From	To	No of Days
9:25 PM 16/03/25	11:00 PM 16/03/25	

3. Past Medical History

- a. When did deceased first complain of or give other indications of his/her last illness? NIE
- b. Date last consulted or took medical advise of his/her last illness?
- c. Have you treated or advised any treatment prior to last illness? ☐ Yes ☐ No
- d. Did the deceased, to your knowledge, receive treatment during the last five year from any other physician, or hospital? ☐ Yes ☐ No

Date	Physician/hospital Name	Nature of Illness	Treatment

4. Accidental Death/Suicide, Homicide

- a. Cause of death, please specify ☐ Accident ☐ Suicide ☐ Homicide ☒ Other Gun Shot Head
- b. Please describe event in detail The Pt brought to Hospital with Hx of Gun Shot in Critical Condition.
- c. Was an inquest/investigation held? ☒ Yes ☐ No
- d. Was an autopsy performed ☐ Yes ☒ No if yes, please describe findings in detail
- if yes, please describe findings

5. Declaration

I hereby declared that to the best of my knowledge and belief the information given herein is true and complete

Signature: Dr. Liaquat Hussain

Name: Dr. Liaquat Hussain

Date of statement: 16/04/25

Contact No. 0314-9000120

Stamp

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