Pak-Qatar Family Takaful Limited

FAMILY TAKAFUL

Form DS-2

Physician's Statement

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

Patient Information	Name of Patient: HAZRAT BILAL	Date of Birth: 25-3-1991
	Patient's Address: DISTRICT HANGU VC Muhammad Khwaja	
Employer Information	Name of employer: Hazrat Bilal	

1. History

(a) Date doctor first consulted due to disability: 10 July 2020 (Day / Month / Year)

(b) Date symptoms first appeared or accident happened: 24 June 2020 (Day / Month / Year)

(c) Date patient ceased work because of disability: Thu 13 2020 (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?

Dr Bilal Dental District Hangu

Name of Doctor / Address / Mobile No.

2. Diagnosis

(a) Date of Last examination/Consultation: Tuesday 21 2020 (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: Yes,

(2). Diagnostic studies and results: Yes,

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 Tue 21 August 2020 (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: 11-08-2020
Attending physician's name: Hazrat Bilal	Specialty: Dentist
Address: Bilal Medico Medical	Telephone No. 0336 9133961

BILAL DENTAL CLINIC
BDS & S.C HANGU
Mob: 0331-4582608

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