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: Abdullah.

Date of Birth: 2-3-1991

Patient's Address: Shakai.

Employer Information

Name of employer: CTC.

1. History

(a) Date doctor first consulted due to disability — 13-8-20 (Day Month Year)

(b) Date symptoms first appeared or accident happened — 13-8-20 (Day Month Year)

(c) Date patient ceased work because of disability — 13-8-20 (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?

Name of Doctor: Dr Nisar Ahmad Address: New HMC Wana Mobile No.: 0333-9951070

2. Diagnosis

(a) Date of Last examination/Consultation — 12-10-20 (Day Month Year)

(b) Diagnosis (including any complications) — RTA. → # (R) Distal R/U.

(c) Subjective symptoms — ↓ ROM. ↓ wrist

(d) Objective findings (including current X-rays, ECG's, laboratory data and any clinical findings):

(1). Clinical Findings — Afond_scal. Over Rt. Reg. (R) wrist

(2). Diagnostic studies and results: — Satisfactory.

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 His or Her Current Jon ☑ Yes ☐ No   ☐ 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? Draving.

(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 ____ 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: [signature] Bhutta	Date: 12/10/20
Attending physician's name: Dr. Nisar Ahmad Bhutta	Specialty: Ortho-Surgeon
Address: DHQ.-Hospital Wana	Telephone No.: 0333-9951070.

Ref No.: GT/CL/2008/00054/1