



Pak-Qatar Family Takaful Limited

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	<i>Niamatullah</i>	Date of Birth	<i>6/4/1979</i>	
	Patient's Address	<i>Spin Masjid Street No 10 Peshawar abad</i>			
Employer Information	Name of employer				
1. History	(a) Date doctor first consulted due to disability	<i>22</i> Day	<i>12</i> Month	<i>2020</i> Year	
	(b) Date symptoms first appeared or accident happened	<i>22</i> Day	<i>12</i> Month	<i>2020</i> Year	
	(c) Date patient ceased work because of disability	<i>22</i> Day	<i>12</i> Month	<i>2020</i> Year	
	(d) Has patient ever had same or similar condition?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, state when and describe			
	(e) Is condition due to injury or sickness arising out of patient's employment?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
	(f) Name the first doctor with full address, consulted by the claimant for the above disability/accident?	<i>Doctor Nazir Saigun Hospital Quetta</i>			
2. Diagnosis	(a) Date of Last examination/Consultation	<i>16</i> Day	<i>02</i> Month	<i>2021</i> Year	
	(b) Diagnosis (including any complications)	<i>Hed c, head & eye broad def cut</i>			
	(c) Subjective symptoms				
	(d) Objective findings (including current X-rays, ECG's, laboratory data and any clinical findings):				
3. Progress	(1) Clinical Findings	<i>X-ray CT Scan, CBC, HBS, HCV had been taken</i>			
	(2) Diagnostic studies and results:	<i>X-ray of CT Scan were normal</i>			
4. Prognosis	(a) Patient is	<input checked="" type="checkbox"/> Ambulatory	<input type="checkbox"/> Bed confined	<input type="checkbox"/> House confined	<input type="checkbox"/> Hospital confined
	(a) Patient has	<input type="checkbox"/> Recovered	<input checked="" type="checkbox"/> Improved	<input type="checkbox"/> Stabilized	<input type="checkbox"/> Retrogressed
Remarks	(a) Is the disability presumed to be reversible?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	(b) Is patient now capable of performing duties of His or Her Current Job?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	(c) What duties of his or her job is patient incapable of performing?				
	(d) Do you expect a fundamental or marked change in future?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	(e) Specify the date by which you presume that the patient will be able to resume his duties/work:	<i>20-01-2021</i>			

Declaration: I hereby declared that the above statements are true and complete to the best of my knowledge.

Signature	<i>[Signature]</i>	Date	<i>8/1/21</i>
Attending physician's name	<i>Dr Nazir S.S.</i>	Specialty	<i>Surgeon</i>
Address	<i>Surgeon Hospital Airport Road</i>	Telephone No.	<i>03353911648</i>

[Signature]
 Dr. Muhammad Z
 M.B.B.S.
 DDHO Quetta

Ref No: GT/CL/2008/0054/1
[Signature]
 Chief Executive
 Sungeen Hospital
 Air Port Road, Quetta.

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