

**SuryaJyoti Life Insurance Company Limited**  
 Head Office - Shanta Plaza, Gyaneshwor, Kathmandu Nepal  
 Tel 4545947/48/50, P.O. Box No. 19433, Email: info@suryajyoti.com

**MEDICAL ATTENDANT'S CERTIFICATE**

(To be filled by treating medical attendant of the insured in his/her last illness)

- This form should be filled in on the basis of the information available from the records maintained by the doctor

<b>Policy No.:</b>	.....
1. What was the full name, age, address and occupation of the patient as per Hospital Records?  a) Name:  b) Age:  c) Address:  d) Occupation:  e) Identification marks:	1.  a).....  b).....  c).....  d).....  e).....
2. What was the date of visit/admission into the Hospital? Please state the details of visit/admission.	2.....
3. Is the patient referred from other hospital/medical institution/doctor?	3.....
4. What was the exact history reported by the patient at the time of visit/admission? (Full history including the dated, duration of ailments, the symptoms narrated etc. to be given)	4.....
5. What was the diagnosis arrived at the Hospital?	5.....
6. Was there any other disease or illness, which preceded or co-existed with the ailment at the time of the patient's admission into the hospital?  If so what was it? Please give details stating  (a) History reported	6.....    (a).....

<p>(b) Date when such was first observed as patient?</p> <p>(c) By whom he/she treated?</p>	<p>(b).....</p> <p>(c).....</p>
<p>7. What was the date of his/her discharge from hospital?</p>	<p>7.....</p>
<p>8. What was the condition when he/she was discharged?</p>	<p>8.....</p>

Certified that the above information is correct as per records of the hospital.

Authorized Signatory: \_\_\_\_\_

Name: \_\_\_\_\_

Designation: \_\_\_\_\_

Name of hospital: \_\_\_\_\_

Postal Address/email: \_\_\_\_\_

Date: \_\_\_\_\_

Seal/Stamp: