



完全喪失工作能力主診醫生證明書(免繳保費/供款者免繳保費)

PERMANENT DISABILITY ATTENDING PHYSICIAN'S STATEMENT (WP / PB)

Note: This statement should be fully completed and signed by Attending Physician. The expense must be paid by insured if necessary.
注意：本表須由被保險人交予主診之註冊醫生填寫，並且保戶必須負責該表填寫費用。

Name of patient: 病人姓名	I.D.#: 身份證號碼	Age: 年齡	Sex: 性別	Occupation: 職業
1. Date on which you first saw the patient for this illness or injury. 首次診治該病人日期				
2. What symptoms did the patient complain of at this first consultation? 該病人首次就診時所患病徵怎樣?				
3a. According to the patient, how long had he/she been experiencing these symptoms or injury? 根據該病人透露，他患此病徵有多久或意外發生日期?			3b. How long do you feel the symptoms had lasted? 你認為該病人患此病徵有多久?	
4. Please state the cause of the permanent disability. 請述完全喪失工作能力原因				
5. Please state how the disability prevents he/she from resuming work in details. 請詳述病人如何因是次疾病影響導致他完全不能回復本來之工作崗位				
6. Please give details of all consultation and treatments given as far as your records go back. 請詳細記錄該病人所有就診及治療				
Date 日期	Complaints & symptoms 主訴及症狀	Diagnosis 診斷	Type of treatments Given 治療措施	Duration of such Treatment 治療持續時間
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.....				
7. What is the present condition of his / her disability? 該病人目前情況如何				
8. Was the patient referred to you by another doctor? If so, please indicate his/her name and address. 該病人是否由其他醫生推薦給你? 若是，請注明醫生姓名及地址。				
9. (a) Names and Address of hospital admitted during this disability. 由於該病徵入住醫院名稱及地址				
(b) Period of hospitalization				
住院天數	FROM	TO
	從	DD/日 MM/月 YY/年	至	DD/日 MM/月 YY/年
(c) Name and Address of other physicians consulted during this disability. 該病人接受其他醫生診治的姓名及地址				
(d) Is further Hospitalization / Surgery necessary? If so, please specify. 是否需要進一步住院治療 / 外科手術? 若有，請詳述				

10. Results of investigation such as neurological examination, laboratory tests, X-ray, etc.
檢查結果例如神經科檢查、實驗室檢查、放射科檢查等

11. Was injury / illness induced from or effected by any of the following which may contribute to the accident / illness and / or lengthen the period of disability ?
下列所示病徵是否引起或影響此次意外 / 疾病導致完全喪失工作能力

(a) Physical defects / congenital anomaly (a) Yes:..... No
身體殘障 / 先天性疾病

(b) Unfavorable past medical history (b) Yes:..... No
既往有不良健康史

(c) Degenerative changes (c) Yes:..... No
退行性改變

(d) Alcohol or drugs (d) Yes:..... No
酗酒或成癮藥物

If any of the above is yes, please give details.
以上若有請詳述

12. (a) Please give the date the Insured was first absent from work.
請提供受保人首次未能工作日期

.....
DD/日 MM/月 YY/年

(b) If the disability was interrupted, please give date insures went back to work.
喪失工作能力中斷，請提供受保人恢復工作日期

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DD/日 MM/月 YY/年

13. If he/she is still totally disabled, how much longer will such disability be expected to continue ?
若他目前仍喪失工作能力，您認為該情況將會持續多久

14. To the best of your knowledge, how the patient ever been treated for the same / related conditions or for any other serious disorders ? If so, please state when and the names of any other hospital(s) and /or doctor(s) attended.
根據您的知識，該病人是否因同一 / 相關病徵或其它嚴重疾病曾接受治療。若有，請詳述時間、醫院名稱或醫生姓名

根據您的知識，該病人是否因同一 / 相關病徵或其它嚴重疾病曾接受治療。若有，請詳述時間、醫院名稱或醫生姓名

Dates	Disease/Disorder	Details of treatment(s)/hospital(s)	Doctor's/Hospital's Name(s)
日期	疾病 / 病徵	詳細治療 / 住院記錄	醫生 / 醫院名稱

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I, the undersigned, hereby declare that I was the doctor in attendance during the last illness of _____ who was insured in China Life Insurance (Overseas) Company Limited Macau Branch under Policy No. _____ and that the foregoing answers are each and all true to the best of my knowledge and belief.

具證明書為中國人壽保險(海外)股份有限公司澳門分公司第_____號保單保戶_____之診病醫師茲於以上各答言句句確實無誤。

Signed : _____ Name of physician (w/ Hospital chop) : _____
簽署 醫生姓名 (連醫院蓋章證明)

Qualification : _____ Address : _____
執業資歷 地址

Date : _____ Telephone No. : _____
日期 電話