Financial Insurance Company Limited
Financial Assurance Company Limited
(each part of AXA)
Building 6 Chiswick Park,
566 Chiswick High Road,
London W4 5HR

Doctors Statement

ONLY TO BE COMPLETED BY DOCTOR

Any fee payable for completion of this form is the claimant's responsibility

Information on Patient

Patient's Name:	
Patient's Address:	
Patient's Date of Birth:	

Information on Disability

Please provide details of sickness/accident Please give the cause:					
First date your patient consulted you for this condition:	|d|d|/|m|m|/|y|y|				
First date of diagnosis:	|d|d|/|m|m|/|y|y|				
First date you certified the patient unfit for work:	|d|d|/|m|m|/|y|y|				
If your patient suffers from more than one illness/injury. Please list them stating the most serious first:					
1.	|d|d|/|m|m|/|y|y|				
2.	|d|d|/|m|m|/|y|y|				
3.	|d|d|/|m|m|/|y|y|				
4.	|d|d|/|m|m|/|y|y|				
Date Patient joined your practice:	|d|d|/|m|m|/|y|y|				
Is the patient's sickness/injury due to self infliction, childbirth, pregnancy or miscarriage, alcohol or drug abuse, Aids or HIV infection, surgical procedures and medical treatment performed for cosmetic reason, civil commotion, riot or war, psychological or any mental condition?		Yes		No	
If 'Yes', please provide details					
Please advise us whether your patient has suffered from this or a related condition before?		Yes		No	
If 'Yes', please give details	**Dates**	**Details**			

If the patient has been admitted to hospital please tell us the following	**Date Admitted**	
	Date Discharged	

Doctor‘s Information	
Doctor‘s Name:	
Telephone Number:	
Doctor‘s Address	**Doctor’s Stamp**
Date:	**Doctor’s Signature:**