can assistance

Attending Physician Declaration
Trip Cancellation

To be completed by the physician. Any professional fees charged are the insured's responsibility.

Contract Number

Patient Information

Name | First name | Gender ☐ M ☐ F | Date of birth (year / month / day)

Information Concerning the Accident or Illness

Diagnosis or nature of the injury or illness: _____

Date the accident happened or first symptoms of the illness appeared: (year / month / day)

Date of first consultation: (year / month / day)

Has this person ever suffered from this illness before? ☐ Yes ☐ No

If so, please specify the date: (year / month / day)

Was the patient hospitalized due to this condition? ☐ Yes ☐ No

If so, please specify the dates: (year / month / day) to (year / month / day)

List all visits and/or treatment dates for this condition from initial consultation to present:

(year / month / day) (year / month / day) (year / month / day) (year / month / day)

Is this condition the complication of an underlying condition? ☐ Yes ☐ No

If so, please specify: _____

Was this patient referred to you by another doctor? ☐ Yes ☐ No

Name and address of the referring doctor: _____

If so, specify the referral date: (year / month / day)

Medical Recommendation as to the Capacity of Travelling

Is this patient the person travelling? ☐ Yes ☐ No

If so, was this patient unable to travel due to this illness or injury? ☐ Yes ☐ No

Indicate the date on which you recommended the trip be cancelled: (year / month / day)

Dates recommended not to travel: (year / month / day) to (year / month / day)

Are there any other reasons why this patient should not travel? _____

Comments

_____

_____

Physician Identification and Signature

Name and address of the physician (Please print): _____

_____

Speciality: _____ Telephone: _____

Date: (year / month / day) Signature of the physician: _____

Physician's stamp

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