

Part C - Physician's Statement

1. Name of patient	2. Date of Birth (mm/dd/yyyy)
3. Date of accident (mm/dd/yyyy)	4. Date first consulted because of this injury (mm/dd/yyyy)
5. Date of last treatment (mm/dd/yyyy)	

6. Describe the exact nature, location, and extent of all injuries sustained. (Attach all medical reports relevant to the treatment of the injury)

7. Were the injuries described solely responsible for the loss of limb or eyesight? YES NO → Give the particulars of any cause or causes (including disease) which contributed to the loss, in the space to the left. (Explain on a separate sheet if necessary)

Complete for Limb Amputations Only

Complete for Loss of Vision Only

8. Which limbs were severed or amputated?

9. On what date(s) did the severances or amputations occur?

10. State the exact point where the amputation was performed or where the severance occurred for each limb lost. If the severance or amputation was below the elbow or knee joint, indicate in item 12 on the chart below the exact point of severance.

11. Reason for amputation(s)?

13. Give the date of exam and vision before the accident.

	Uncorrected	Corrected
Date: (mm/dd/yyyy)		
(Snellen Notations)	Right eye	
	Left eye	

14. State the loss of vision.

15. Give the date you first determined vision was irreversibly reduced to 20/200 (Snellen Notation) or less with correction, and the vision remaining in each eye on that date.

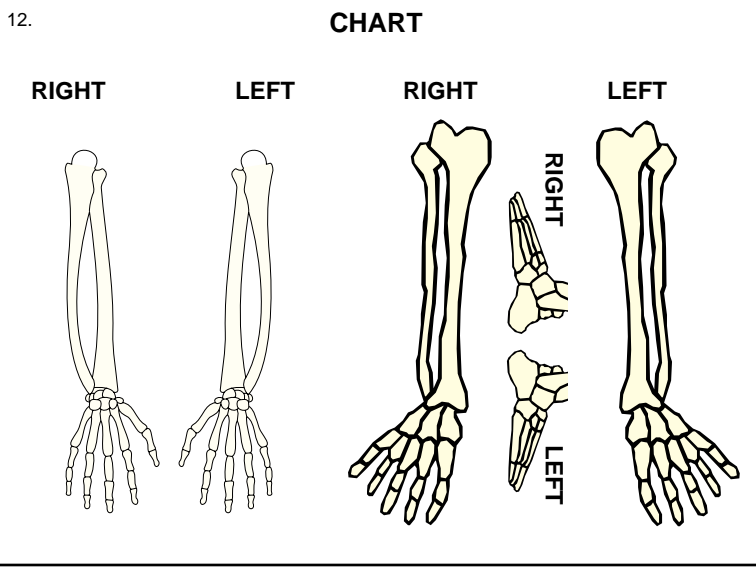
	Uncorrected	Corrected
Date: (mm/dd/yyyy)		
(Snellen Notations)	Right eye	
	Left eye	

16. Give the date and vision found on last eye examination.

	Uncorrected	Corrected
Date: (mm/dd/yyyy)		
(Snellen Notations)	Right eye	
	Left eye	

17. Is recovery of useful vision possible by operation or treatment?

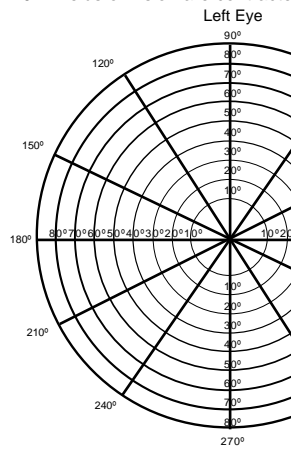
		Yes	No		Yes	No
Right eye	Operation			Treatment		
Left eye	Operation			Treatment		



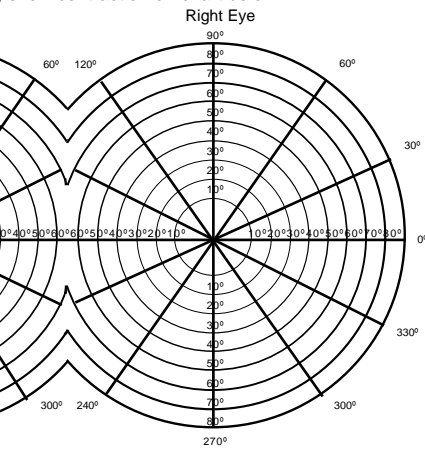
18. If eye is enucleated, give date.

19. If fields of vision are contracted, show contraction on chart below.

Left Eye



Right Eye



I certify that all of my statements are true to the best of my knowledge and belief.

Physician's Signature _____ Date (mm/dd/yyyy) _____

Physician's Name (type or print) _____

Office address - number and street _____

City, state and ZIP code _____

Telephone number () _____	Fax number () _____
Area code	Area code