Physician Certification for Accident-Related Claims

Patient Information

Full Name _____

Date of Birth _____

Claim/Policy Number _____

Address _____

Accident Details

Date of Accident _____

Type of Accident _____

Location of Accident _____

Brief Description of Accident _____

Medical Assessment

Date First Seen _____

Date Last Seen _____

Diagnosis _____

Nature and Extent of Injuries _____

Treatment Provided _____

Current Status/Prognosis _____

Is the injury consistent with the accident described? _____

Is the patient able to return to work/school/normal activities? _____

Additional Comments

_____

Physician Name

_____

Date

_____

Signature

Medical License Number