

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.

Date: (mm/dd/yyyy)

(Snellen Notations)	Right eye	Uncorrected	Corrected
	Left eye		

14. State the loss of vision.

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

Date: (mm/dd/yyyy)

(Snellen Notations)	Right eye	Uncorrected	Corrected
	Left eye		

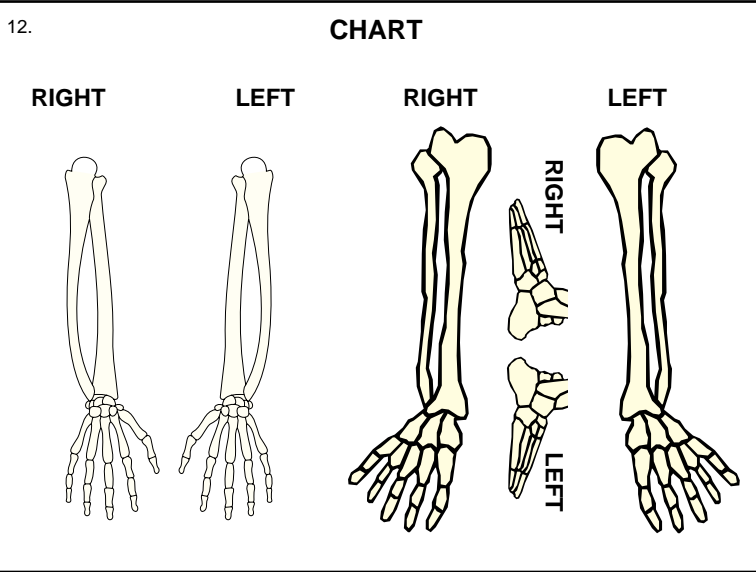
16. Give the date and vision found on last eye examination.

Date: (mm/dd/yyyy)

(Snellen Notations)	Right eye	Uncorrected	Corrected
	Left eye		

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

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



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 () _____ Area code _____

Fax number () _____ Area code _____