Medical Certificate (Gastroentieritis) for Hospitalization / Surgery

To: NIPPON LIFE INSURANCE COMPANY

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ATTENDING PHYSICIAN'S STATEMENT OF HOSPITALIZATION / SURGERY

1. Patient's Name — Chart No. ( ) | **Sex** Male / Female | **Date of Birth** month / day / year

2. Name of Disease / Injury — *Multiple options allowed
1. Acute gastritis / Acute enterocolitis | 2. Chronic gastritis | 3. Other disease / injury ( )

3. Date of Initial Consultation — month / day / year

4. Symptoms / Tests on Admission

a. Methods of Medical Consultation — *Single option
1. General Outpatient Visit | 2. After-hours Outpatient Visit | 3. Emergency Transport | 4. Other ( )

b. Reason for Hospitalization — *Single option
1. Patient's Request | 2. Doctor's Recommendation → If "Doctor's Recommendation", Please indicate
Medical Basis for Hospitalization

c. Symptoms on Admission — *Multiple options allowed
1. None | 2. Abdominal Pain | 3. Fever | 4. Vomiting | 5. Diarrhea | 6. Hematemesis | 7. Rectal Bleeding

d. Oral Intake on Admission — *Single option
1. Generally Possible | 2. Generally Impossible

e. Tests on Admission — *Multiple options allowed
1. None | 2. Blood Test | 3. Abdominal ultrasound | 4. Upper GI endoscopy | 5. Lower GI endoscopy | 6. X-ray | 7. CT scan | 8. Other ( )

f. Tests Revealing Abnormal Findings Requiring Hospitalization — *Multiple options allowed
1. None | 2. Blood Test | 3. Abdominal ultrasound | 4. Upper GI endoscopy | 5. Lower GI endoscopy | 6. X-ray | 7. CT scan | 8. Other ( )

5. Treatment During Hospitalization (excluding surgery)

a. Period of Hospitalization

1st from month / day / 20 year ~ till month / day / 20 year — 1. Discharged (Including Transfer to Another Hospital) | 2. Died during Hospitalization | 3. Currently Hospitalized | 4. Transferred to Another Department

2nd from month / day / 20 year ~ till month / day / 20 year — 1. Discharged (Including Transfer to Another Hospital) | 2. Died during Hospitalization | 3. Currently Hospitalized | 4. Transferred to Another Department

If there are three or more hospitalizations, please indicate admission and discharge dates. (If currently hospitalized, note "Currently Hospitalized.")

b. Treatment During Hospitalization — *Multiple options allowed
1. None (Bed Rest / Tests only) | 2. Fasting | 3. Oral Medications | 4. Single Infusion | 5. Continuous Infusion (24H) | 6. Other ( )

6. Surgery Performed for Disease / Injury in Section 2 Above (Including Continuous Drainage / Ethanol Injection Therapy)

Surgery

Name of Surgery — 1. Left / 2. Right / 3.Bilateral
Date of Surgery — month / day / 20 year

Name of Surgery — 1. Left / 2. Right / 3.Bilateral
Date of Surgery — month / day / 20 year

Remarks — If other surgeries were performed, please indicate the surgery procedure name and date.

7. Treatment Received as Outpatient

Year / Month of Outpatient Visit	Total Days	Please circle the dates of outpatient treatment for the disease / injury in Section 2 above following discharge. (Including home visits and excluding scheduled appointment dates.)
year month	days	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
year month	days	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
year month	days	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

8. Prior Medical Care

1. Yes — Medical Institution Name
2. No — (Treatment Period) From / to / (approximate dates)

9. Mental Capacity

If the patient cannot understand the meaning of claiming and receiving insurance money/benefits, mark with a circle. Unable

I hereby certify that the above information is true and complete to the best of my knowledge.

Medical Institution

Institution Name :
Adress :
Department :
Phone Number :
Physician's Name :
Country :

Date of Certification: month / day / year

(Signature)

Please mark (with a circle) one of the dotted options.