Medical Certificate (Hemorrhoid / Anal Fistula / Anal Fissure) for Hospitalization / Surgery

To: NIPPON LIFE INSURANCE COMPANY

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ATTENDING PHYSICIAN'S STATEMENT OF HOSPITALIZATION / SURGERY

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

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

2. Name of Disease / Injury *Multiple options allowed

1. Hemorrhoid 2. Anal Fistula 3. Anal Fissure 4.Other ( )

3. Date of Initial Consultation month / day / year

4. Reason for Hospitalization *Single option

1.Patient's Request 2. Doctor's Recommendation

5. Period of Hospitalization

1st from month / day / 20 year ~ till month / day / 20 year

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.")

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

Surgery

Name of Surgery	Date of Surgery
1. Left 2. Right 3.Bilateral	month / day / 20 year
1. Left 2. Right 3.Bilateral	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 2. No

Medical Institution Name

(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) _____

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