Medical Certificate (Bronchitis) 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

*No mark with a circle needed

Bronchitis / Upper Respiratory Inflammation / Upper Respiratory Infection

Disease / injury required hospitalization for treatment other than above ( )

3. Date of Initial Consultation

month / day / year

4. Reason for Hospitalization

*Single option

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

5. Imaging Tests Revealing Abnormal Findings on Admission

*Multiple options allowed

1. None / 2.X-ray / 3. CT scan / 4. Other ( )

6. Oral Intake on Admission

*Single option

1. Generally Possible / 2. Generally Impossible

7. 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.")

8. Treatment during Hospitalization

*Multiple options allowed

1. Oral Medications / 2. Single Infusion / 3. Continuous Infusion (24H) / 4. Other ( )

9. 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

1. Left / 2. Right / 3.Bilateral

Date of Surgery

month / day / 20 year

month / day / 20 year

Remarks

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

10. Outings / Overnight Stays

Outings: times Overnight Stays: days

11. 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

12. Prior Medical Care

1. Yes / 2. No

Medical Institution Name

(Treatment Period) From / to / (approximate dates)

13. 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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