Medical Certificate (Vertigo) for Hospitalization / Surgery To: NIPPON LIFE INSURANCE COMPANY

ATTENDING PHYSICIAN'S STATEMENT OF HOSPITALIZATION / SURGER

TTENDING	PHYSICIAN'S S	TATEMENT OF HOSPITALIZATION / SURGERY									
1. Patient's Name		Chart No. Sex Male of Birth month day year									
2. Name of Disease	*Multiple options allowed 1. Benign Paroxysmal Positional Vertigo 2. Meniere Disease 3. Vestibular Neuritis 4. Central Vertigo										
/ Injury	5. Vertigo of Unknown Origin 6. Other										
3. Date of Initial Consultation	month day	year									
4.	a. Methods of Medical Consultation	*Single option 1. General Outpatient Visit 2. After-hours Outpatient Visit 3. Emergency Transport 4. Other ()									
Symptoms / Tests on Admission	b. Reason for Hospitalization	*Single option 1.Patient's Request 2. Doctor's Recommendation									
	c. Imaging Tests Revealing Abnormal Finding on Admission	*Multiple options allowed 1. None 2. CT scan 3. MRI 4. Other ()									
	d. Nystagmus or Admission	*Single option 1. None 2. Present									
	e. Nausea on Admission	*Single option 1. None 2. Present									
	f. Impaired Walking and Standing on Admission	*Single option 1. None 2. Present									
5. Treatment During Hospitalization (excluding	a. Period of Hospitalization	1st / / / 2 0 ~ / / / 2 0 . Died during transfer to Autother Hospital) from month day year till month day year (a.). Died-larged (including) (hospitalization) (hospital									
surgery)	b. Treatment During Hospitalization	*Multiple options allowed 1. Bed Rest 2. Oral Medications 3. Single Infusion 5. Continuous Infusion (24H) 6. Other ()									
6. Surgery P	erformed for Diseas	se / Injury in Section 2 Above (Including Continuous Drainage / Ethanol Injection Therapy)									
Surgery	Name of Surgery	1. Left 2. Right 3. Bilateral 2. Right 2. Right 2. Right 3. Bilateral 4. Bilater									
	Remarks	other surgeries were performed, please indicate the surgery procedure name and date.									
7.	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.)									
Treatment Received as Outpatient	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		ot understand the meaning of claiming ance money/benefits, mark with a circle.									
I hereby certify the	Institution Name : Adress : Department : Phone Number : Physician's Name :	n is true and complete to the best of my knowledge. Date of Certification: month / day / year (Signature)									
1	Country :										