Medical Certificate (Herniated discs etc.) for Hospitalization / Surgery

To: NIPPON LIFE INSURANCE COMPANY

ATTENDING PHYSICIAN'S STATEMENT OF HOSPITALIZATION / SURGERY

a 3 3 3 4 1 0 0 1 1 a

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. Herniated discs (Cervical Spine / Thoracic Spine / Lumbar Spine)
2. Degenerative Spondylosis (including Cervical Spondylosis and Lumbar Spondylosis)
3. Low back pain
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. Mobility on Admission — *Single option
1. Walking
2. Cane
3. Walker
4. Wheelchair
5. Other ( )

6. Symptoms on Admission — *Multiple options allowed
1. Neck pain
2. Lower back pain
3. Numbness
4. Weakness of upper or lower extremities
5. Bladder/bowel dysfunction
6. Other ( )

7. Objective Findings — *Single option
1. None
2. Present → If "Present," please indicate

8. Details of Objective Findings

9. 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.")

10. Treatment During Hospitalization (excluding surgery) — *Multiple options allowed
1. Bed rest
2. Oral and topical medications
3. Rehabilitation (including PT, physiotherapy, and exercise therapy)
4. Trigger point injections
5. Nerve root block injections
6. Other ( )

11. 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
		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.	

12. Outings/ Overnight Stays — Outings: times Overnight stays: days

13. 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

14. Prior Medical Care
1. YES — Medical Institution Name
2. NO — (Treatment Period) From / To / (approximate dates)

15. 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 :
Address :
Department :
Phone Number :
Physician's Name :
Country :

Date of Certification: month / day / year

(Signature)