5582604

運動器損傷給付金以外のご請求の場合は入院・手術・通院証明書をご使用ください。

To:Sumitomo Life Insurance Company

English Only:Please type or write in block letters

Musculoskeletal Injury certificate 英文診断書（運動器損傷証明書）

1.Name		Sex M／F	Date of Birth	______(m)/______(d)/______(y)
2.Name/site of Injury			3.Date of Accident	______(m)/______(d)/______(y)

4. Details of Injury state

If a definitive diagnosis is related to the conditions below, Please circle appropriate.

- ◯ Fracture / Insufficiency Fx / Compression Fx(＊)
  (＊)includes one caused by disease
- ◯ Rupture of the ligament
- ◯ Rupture of the tendon
- ◯ Rupture of the meniscus

  (Complete Tear / Partial Tear)
- ◯ Other（specify： ）

*Please make sure to circle al least one of the above.

5. Initial Consultation	______(m)/______(d)/______(y)
6.Period of Hospitalization	From ______(m)/______(d)/______(y) To ______(m)/______(d)/______(y)
7.Previous Doctor	Doctor’s Name / Name of Institute

8.Cause of Injury		9.Pre-existing Disorder	Part of Body / Detail of Disorder

10.Type of Fixation	(1)Plaster (2)Splint (3)Other（ ）	Period of Fixation	From	____(m)/____(d)/____(y)
			to	____(m)/____(d)/____(y)

11.Operation

Operation performed for this injury

Name of Operation		Date of Operation	____(m)/____(d)/____(y)

Please circle appropriate

- ◯ Open Surgery
- ◯ Surgery of Extremity in which operative site is MP joint and/or proximal
- ◯ Closed Surgery
- ◯ Surgery of Dermatoplasty(Skin･Flap)with grafts equal to 25cm^{2}or larger
- ◯ Surgery of Muscle,Tendon and Ligament

12. Outpatient Treatment Certificate

Month/Year		Please circle day(s) of ambulatory care or doctor’s visit for above 2. after discharge	Total
(m)	(y)	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	day(s)
(m)	(y)	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	day(s)
(m)	(y)	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	day(s)
(m)	(y)	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	day(s)
(m)	(y)	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	day(s)

These statements are true and complete to the best of my knowledge and belief.

Name of hospital

Address of hospital

Signature of doctor

Date ______/______/______
(Month) (Day) (Year)

Country ____________