To AXA LIFE INSURANCE COMPANY Ltd. JP

Attention；Please type or write in block letters (In English only)

ATTENDING PHYSICIAN'S STATEMENT（HOSPITALIZATION/OPERATION）

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

1. Name of Disease or Injury for Hospitalization			Onset Date of Disease/Injury	Please circle below
	(a) Name of Disease or Injury for Hospitalization		day/month/year / /	Physician's Opinion / Patient's Report
	(b) Cause of the above (a)		day/month/year / /	Physician's Opinion / Patient's Report
	(c) Complications		day/month/year / /	Physician's Opinion / Patient's Report

2. In Case of Acute Myocardial Infarction	60days after the initial consultation, was it still necessary to continue limiting the work done by the patient? ("limiting the work" here refers to a state whereby the patient can do sedentary or light work but restrictions are necessary regarding more demanding activities)	Yes	No
3. In Case of Stroke	Do such objective, neurological sequelae as dysphasia, ataxia and paralysis still exist 60 days after the initial consultation?	Yes	No

Detail the sequelae

4. In Case of Malignant tumor or intraepithelial neoplasia	Date of Diagnosis	Cancer tissue	TNM Staging		Was histopathological examination performed?	Yes	No
	day/ month/ year	primary lesion	T				
	/ /	recurrence	N		Definitive histopathological diagnosis		
		transitions	M				

5. Period of Medical Treatment (From The First Day of Medical Consultation.)	From day/ month/ year till day/ month/ year	Please circle below
	/ / ～ / /	Ending Consultation / Under Medical Treatment

6. Period of Hospitalization		From day/ month/ year till day/ month/ year	Please circle below
	The 1st.	/ / ～ / /	Inpatient / Discharged
	The 2nd.	/ / ～ / /	Inpatient / Discharged
	The 3rd.	/ / ～ / /	Inpatient / Discharged

7. Previous Physician or Referring Physician	Yes	No	Name / Address of Medical Institution	The First Day of Medical Consultation.	day/ month/ year / /
8. Past Medical History and Chronic Disease	Yes	No	Name / Address of Medical Institution	Period of Treatment	From day/month/year till day/month/year / / ～ / /

9.Progress from Onset of Symptom/Injury till Initial Consultation ※Please indicate when and how the symptom developed.

10. Operation

Please choose a number from ①～⑫.

①Craniotomy ②Trepanation ③Thoracotomy (include open Heart surgery) ④Thoracoscopic ⑤Laparotomy ⑥Laparoscopic ⑦ Laser ⑧Fiberscopic or Catheter ⑨Percutaneous ⑩Transurethral ⑪Transvaginal ⑫Others

Please choose an alphabet from（A）～（N）.

(1) Surgery of Bone and Muscle - Open (A), Close (B)
(2) Trepanation - a hole newly made (C), using an existing hole (D)
(3) Dermatoplasty, the size of grafting area is equal to 25c㎡ or larger - Yes (E), No (F)
(4) Intraoral operation, sharpening jawbones - Yes (G), No (H)
(5) Fingers and toes, operative site is including MP joint and extending to center - Yes (I), No (J)
(6) Removal of foreign bodies from bones - removal of pin and bolt (K), Others (L)
(7) Open Surgery on muscles, tendons, or ligaments - Yes (M), No (N)

Number	Details of Operation	Name of Operation	L or R	Date of Operation	day/ month/ year
					/ /
					/ /
					/ /

11. Radiotherapy	Regions		Period of Radiation	from day / month/ year ～ until day/ month/ year	Total dose		Gray
				/ / ～ / /			

12. Treatment Received as Outpatient

Please circle day(s) of ambulatory care for above 1.(Disease or Injury)※within 120days after discharge.

Month		Year		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	Total	Day(s)
Month		Year		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)
Month		Year		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)
Month		Year		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)
Month		Year		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.

Hospital's or Clinic's

Name；
Address；
Department；
Telephone Number；
E-mail address；
Physician's Name；
Country；

Date	day/ month/ year / /
Signature	

【Back】 Please do not fill in this column.

To AXA LIFE INSURANCE COMPANY Ltd.JP

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ATTENDING PHYSICIAN'S STATEMENT（HOSPITALIZATION/OPERATION）診療内容明細書（入院・手術等証明書）（対訳・記入例）

Patient's Name（患者氏名）	Taro Akusa　Chart No. (123456)	Sex（性別） Male（男） / Famale（女）	Date of Birth（生年月日） day/ month/ year: 10 / 10 / 1942

1. Name of Disease or Injury for Hospitalization（入院の原因となった傷病名）

		Onset Date of Disease/Injury（傷病発生年月日） day/month/year	Please circle below
(a) Name of Disease or Injury for Hospitalization（入院の原因となった傷病名）	Acute Myocardial Infarction	1 / 1 / 2013	Physician's Opinion（医師推定） / Patient'sReport（患者申告）
(b) Cause of the above (a)（(a)の原因）	arteriosclerosis	1 / 1 / 2013	Physician's Opinion（医師推定） / Patient'sReport（患者申告）
(c) Complications（合併症）	arrhythmia	1 / 1 / 2013	Physician's Opinion（医師推定） / Patient'sReport（患者申告）

2. In Case of Acute Myocardial Infarction（急性心筋梗塞の場合）

60days after the initial consultation, was it still necessary to continue limiting the work done by the patient?
("limiting the work" here refers to a state whereby the patient can do sedentary or light work but restrictions are necessary regarding more demanding activities)
（初診日より60日時点において労働を制限し続けることが必要でしたか？）
（「労働を制限する」ことは、患者は座業や軽作業を行うことはできるが、それ以上の活動に関して制限が必要な状態を指します）

Yes / No

3. In Case of Stroke（脳卒中の場合）

Do such objective, neurological sequelae as dysphasia, ataxia and paralysis still exist 60 days after the initial consultation?
（初診日より60日時点において不全失語症、運動失調症および麻痺等の中枢神経系の後遺症は存在していますか？）

Yes / No

Detail the Sequelae（詳細について）

4. In Case of Malignant tumor or intraepithelial neoplasia（悪性新生物または上皮内新生物の場合）

Date of Diagnosis（診断確定日） day/ month/ year	Cancer tissue（癌組織）	TNM Staging（TMN分類）	
/ /	primary lesion（原発巣）	T	
	recurrence（再発）	N	
	transitions（転移）	M	

Was histopathological examination performed?（病理組織学的検査を実施されましたか？） Yes / No

Definitive histopathological diagnosis（最終病理診断病名）

5. Period of Medical Treatment（From The First Day of Medical Consultation.）（治療期間（初日から））

From day/ month/ year till day/ month/ year: 1 / 1 / 2013 ～ 31 / 5 / 2013

Please circle below: Ending Consultation（終診） / Under Medical Treatment（現在加療中）

6. Period of Hospitalization（入院期間）

	From day/ month/ year till day/ month/ year	Please circle below
The 1st.	1 / 1 / 2013 ～ 31 / 3 / 2013	Inpatient（入院中） / Discharged（退院）
The 2nd.	/ / ～ / /	Inpatient（入院中） / Discharged（退院）
The 3rd.	/ / ～ / /	Inpatient（入院中） / Discharged（退院）

7. Previous Physician or Refferring Physician（前医または紹介医）

Yes / No

Name / Address of Medical Institution（医療機関名/住所）

The First Day of Medical Consultation.（初診日） day/ month/ year: / /

8. Past Medical History and Chronic Disease（既往症・持病）

Yes / No

Name / Address of Medical Institution（医療機関名/住所）

Period of Treatment（治療期間） From day/month/year till day/month/year: / / ～ / /

9.Progress from Onset of Symptom/Injury till Initial Consultation ※Please indicate when and how the symptom developed.（症状または怪我の発生から初診までの経緯（いつ、どのように発生したかについて記載してください）

Patient fell down suddenly in a stop on January 1 and urgently convey it. It enforces an operation the next day. I leave the hospital on March 31.

10. Operation（手術）

Please choose a number from (1)～(12).（手術の術式について①～⑫のいずれかを選択し、「術式」に記載してください）
①Cranitomy（開頭術）②Trepanation（穿頭術）③Thoracotomy (include open Heart surgery)（開胸術（開心術を含む）④Thoracoscopic（胸腔鏡下手術）⑤Laparotomy（開腹術）⑥Laparoscopic（腹腔鏡下手術）⑦ Laser（レーザー手術）⑧Fiberscopic or Catheter（ファイバースコープまたはバスケットカテーテルによる手術）⑨Percutaneous（経皮的）⑩Transurethral（経尿道的）⑪Transvaginal（経膣的）⑫Others（その他）

Please choose an alphabet from (A)～(N).（手術の内容について、該当する場合は「手術の内容」に記載してください）
(1) Surgery of Bone and Muscle - Open (A),Close (B)（筋骨関係の手術の場合、観血は（A）、非観血は（B））
(2) Trepanation - New born hole (C),existing bone hole (D)（穿頭術の場合、新たな穿頭は（C）、既存の穿頭孔を使用する場合は（D））
(3) Dermatoplasty, the size of grafting area is equal to 25c㎡ or larger - Yes (E),No (F)（植皮術の場合、25c㎡以上の場合は（E）、未満の場合は（F））
(4) Intraoral operation,sharpen jawbone -Yes (G),No (H)（口腔内手術の場合、顎骨を削っている場合は（G）,削っていない場合は（H））
(5) Fingers and toes, operative site is including MP Joint and extending to center - Yes (I),No (J)
（手指・足指の手術の場合、MP関節を含んで中枢側に及ぶ場合は（I）、及ばない場合は（J））
(6) Removal of foreign bodies from bones - removal of pin &bolt (K),Others (L)（骨内異物除去術の場合、抜釘術は（K）,それ以外は（L））
(7) Open Surgery on muscles, tendons, or ligaments - Yes (M),No (N)（筋・腱・靭帯の切断・切開・縫合を伴う場合は（M）、伴わない場合は（N））

Number（術式）	Details of Operation（手術の内容）	Name of Operation（手術名）	L or R（左右一対の）	Date of Operation（手術日） day/ month/ year
8		percutaneous transluminal coronary angioplasty		2 / 1 / 2013
				/ /
				/ /

11. Radiotherapy（放射線治療）

Regions（照射部位）		Period of Radiation（照射期間）	From day/ month/ year till day/ month/ year	Total dose（総線量）		Gray
			/ / ～ / /			

12. Treatment Received as Outpatient（通院期間）

Please circle day(s) of ambulatory care for above 1.(Disease or Injury)※within 120days after discharge.

Month	Year	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	Total	
4	2013	6, 11, 17, 24	4	Day(s)
5	2013	8, 22	2	Day(s)
				Day(s)
				Day(s)
				Day(s)

These statements are true and complete to the best of my knowledge and belief.（上記のとおり証明いたします）

Hospital's or Clinic's（病院または診療所）

Name（病院名）； Honolulu Hospital
Address（住所）； 111A Street Honolulu ABC123456，USA
Department（病院各科）； cardiovascular medicine
Telephone Number（電話番号）； 123-456-7890
E-mail address（メールアドレス） info@honolulu hospital.com.
Physician's Name（医師名）； Tomas Brown
Country（国名）； the U.S.A

Date（証明日） day/ month/ year: 31 / 5 / 2013

Signature（署名） Tomas Brown