

YOUNG MARINES

Attending Physician's Statement

PLEASE PRINT

(Please complete and mail to Young Marine National Headquarters, P.O. Box 70735 Southwest Station, Washington DC 20024-0735)

PART I: Patient's Personal Information (To be completed by Young Marine Unit)

Last Name _____ First Name _____ Middle Initial _____
Age _____ Date of Birth ___/___/___ Social Security Number _____
Home Address _____ City _____ State ___ Zip Code _____
Parent/Guardian Name _____ Relationship _____
Home Telephone Number (____) _____ Work Telephone Number (____) _____

PART II: Authorization (To be Completed by Attending Physician)

I hereby authorize NATIONAL ACCIDENT INSURANCE UNDERWRITERS, INC. or its representatives to inspect all x-ray pictures, clinical records and to obtain full information, including etiology, diagnosis and prognosis, or other data that may be in your possession or under your control, and to make copies of the same or any portion, thereof, pertaining to the subject patient.

Date _____ Signed _____ (Attending Physician) (Degree)

PART III: Questionnaire for Attending Physician

1. Diagnosis (describe nature of illness or injury):

2. Is condition the result of ___ illness/ ___ injury? (Check appropriate blank)

What date did the illness commence or injury occurred? _____

3. Has the patient had treatment for the same or related condition before? Yes No Unknown (Check appropriate blank) If yes, when and why?

4. On what date were you first consulted for this condition? _____

Give dates of treatment(s): In Office _____ At Home _____

5. If hospitalized, give name and address of hospital and dates of in-patient care. Name of

Hospital _____ Dates: (From/To) _____

Hospital Address _____ State _____ Zip Code _____

Hospital Telephone Number (____) _____

6. If surgery was performed, please describe:

7. Prognosis:

Date: _____ Signed: _____ (Attending Physician) (Degree)