Form A 様式A

- 1. This form is used for claiming the social insurance benefit. この様式は社会保険の給付の申請に使用されます。
- 2. This form should be completed and signed by either the attending physician or the superintendent of a hospital / clinic. この様式は担当医が書き、かつ署名してください。
- 3. One form for each month, One form for hospitalization / outpatient and home visit. 各月ごと、入院・入院外ごとに付きこの様式1枚が必要です。

Attending Physician's Statement 診療内容明細書

1.Name of patient (Last, First) 患者名	Age (Date of Birth) 年齢	_	Sex (Male / Female) 性別(男/女)
2.Name of Illness or Injury 傷病名			
3.Date of First Diagnosis : 初診日			
4.Days of Diagnosis and Treatment : 診療日数	days		
5.Type of Treatment 治療の分類			
□ Hospitalization : from 入院 自	, 20	to 至	, 20
□ Out patient or Home Visi <u>t</u> : 入院外	, 20 , 20		, 20 , 20
6.Nature and Condition of Illness or In 症状の概要	njury(in brief)		
7.Prescription, operation and any other 処方、手術その他の処置の概要	r treatments(in brief)		
8.Was the treatment required as a res 治療は事故の障害によるものですか?	ult of an accidental injury?	YES ロ はい	NO ロ いいえ
9.Itemized amounts paid to Hospital a 治療実費	nd/or Attending Physician :	Form 様式B	В
10.Name and address of Attending Phy 担当医の名前及び住所	ysician		
Name 名前 : Last 姓	First 名		
Address住所:Home 自宅			Phone
Office 病院又は診療所		Phone	
Date 目付	Signature 署	名	
	Reference number of		nysician 担当医 l record(if applicable)

診療記録の番号