SECTION 4: PHYSICIAN'S STATEMENT (TO BE COMPLETED BY PHYSICIAN ONLY)

PATIENT INFORMATION

Patient's Name	Date of Birth

Physician Information

Examining Physician's Name	Specialty	Street Address

City	State	Zip Code	Phone	Fax

Are you the patient's primary care physician?	If NO, primary care physicians name	Phone	Was the patient referred to you by the primary care physician?
☐ YES ☐ NO			☐ YES ☐ NO

PATIENT'S DIAGNOSIS

Diagnosis	ICD Code	On what date did the symptoms/injury first appear?	Did you perform an actual examination?	Date of initial examination:
			☐ YES ☐ NO	

Please list all dates of examination and treatment	Is this condition a complication of an underlying condition? If yes, please explain ☐ YES ☐ NO

If the patient is our insured traveler, on what date did he/she become medically unable to travel?	How long will the patient be disabled?	Did you advise that the trip should be cancelled or interrupted due to the patient's medical condition? If yes, what date? ☐ YES ☐ NO DATE_____

Please provide details explaining the patient's diagnosis. If you advised the patient that the trip should be cancelled or interrupted due to this medical condition, please explain the basis for your travel recommendation. If this is due to an injury, please give details of the injury.

Please provide details surrounding your prior treatment of this patient.

BY MY SIGNATURE AND STAMP BELOW, I HEREBY CERTIFY THAT THE ABOVE IS TRUE AND CORRECT.

Physician Signature	Print Name	Tax ID	Date