



**TAKAFUL IKHLAS FAMILY BERHAD Registration No.200201025412 (593075-U)**

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**ATTENDING PHYSICIAN STATEMENT  
(TOTAL / PARTIAL PERMANENT DISABILITY)**

**Reminders :**

- 1 This form must be completed by the certified Medical Officer who had treated the patient.
- 2 Any cost incurred in relation to this report is to be borne by the patient.

CERTIFICATE NO. \_\_\_\_\_

**A. PATIENT'S PERSONAL DETAILS**

1 a. Name \_\_\_\_\_

b. NRIC No. New \_\_\_\_\_ Old \_\_\_\_\_

c. Age \_\_\_\_\_ d. Sex Male ☐ Female ☐

2 Occupation : \_\_\_\_\_

**B. BACKGROUND**

1 Please describe your patient's illness and disease symptoms

2 a. Are you the claimant's usual medical attendant? ☐ Yes ☐ No

b. If yes, how long have you been his private medical attendant?

c. What date does your record commence?  
DD / MM / YYYY

3 a. Date of first consultation for this disability.  
DD / MM / YYYY

b. Was the patient referred from clinic / hospital?  
If Yes, please state the clinic's / hospital's name.

c. Date patient first absent from work.  
DD / MM / YYYY

d. Date of admission to hospital, if any.  
DD / MM / YYYY

e. When was the last follow-up of the patient for the above illness, if any.  
DD / MM / YYYY

4 a. Has your patient suffered any previous episode of this disability? ☐ Yes ☐ No

b. If yes, please give details, dates and periods of absence from work

5 a. Is this disability related to any other condition which your patient has suffered in the past? ☐ Yes ☐ No

b. If yes, please give details including 1st date of diagnose /

6 Does the patient suffer any illness such as diabetes mellitus, hypertension, ischemic heart disease or etc?

Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date 1st diagnosed _____
Diabetes Mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date 1st diagnosed _____
Others	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of illness: _____ Date 1st diagnosed _____

7 a. Do you have reason to suspect that this illness / injury is included by the influence of alcohol or drugs, pregnancy or child birth, deliberate action, HIV infection, AIDS or mental or nervous disorder? ☐ Yes ☐ No

b. Does the participant's condition related to attempted suicide or willful self injury ☐ Yes ☐ No

Details:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**C. PATIENT'S PRESENT CONDITION**

1 Please state a precise diagnosis of his / her present illness

2 a. Is the patient suffering from any other conditions? ☐ Yes ☐ No

b. If yes, does it affect the condition described above?

<p>3 Ever since the diagnosis of his / her condition, has your patient;</p> <p>a. recovered? If yes, please give date</p> <p>b. improved? If yes, please give date</p> <p>c. experience no changes</p> <p>d. deteriorate</p>	<div> <div> <div></div><div></div> </div> <div>DD</div> </div> <div> <div> <div></div><div></div> </div> <div>MM</div> </div> <div> <div> <div></div><div></div><div></div><div></div> </div> <div>YYYY</div> </div>
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DD

MM

YYYY

☐ Yes   ☐ No
 
☐ Yes   ☐ No

3 What do you consider that your patient is capable of?	<input type="checkbox"/> Following his / her normal occupation on a full time basis <input type="checkbox"/> Following his / her normal occupation on a part time basis <input type="checkbox"/> Following a different occupation <input type="checkbox"/> Cannot perform any occupation										
4 What aspect of the patient's illness renders the patient unable to perform <b>any occupation</b> ? Please give details.											
5 What do you consider your patient's disability to be?	<input type="checkbox"/> Total permanent <input type="checkbox"/> Partial permanent										
6 If you consider that the patient is under Partial Permanent Disability (PPD), please describe the part of the body which was under PPD. (Please draw the picture for further explanation)											
7 Please state the percentage of permanent disability of the patient (from 100% use of body), and the date commenced.	Percentage : _____ Date of commence disability: _____										
8 Does he have any cognitive impairment? If Yes, please give details.											
9 What is power of both the upper and the lower limbs during his last visit	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Parts of limb</th> <th style="width: 40%;">Muscle Power</th> </tr> </thead> <tbody> <tr><td>Right upper limb</td><td></td></tr> <tr><td>Right lower limb</td><td></td></tr> <tr><td>Left upper limb</td><td></td></tr> <tr><td>Left lower limb</td><td></td></tr> </tbody> </table>	Parts of limb	Muscle Power	Right upper limb		Right lower limb		Left upper limb		Left lower limb	
Parts of limb	Muscle Power										
Right upper limb											
Right lower limb											
Left upper limb											
Left lower limb											
10 Is the participant suffered any loss of vision? If Yes, during his visitation, what is his current visual acuity	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Right Eye</th> <th style="width: 50%;">Left Eye</th> </tr> </thead> <tbody> <tr><td style="height: 20px;"></td><td></td></tr> </tbody> </table> <p style="margin-top: 5px;">Please give details:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	Right Eye	Left Eye								
Right Eye	Left Eye										
11 When do you think the patient will be able to resume working either to his present job or alternative employment?											
F. FURTHER / ADDITIONAL INFORMATION											
1 Please state any information which you feel would be helpful in the assessment of your patient's claim.											
2 Do you have any diagnosis or reports from hospitals or consultants that would help our consultant medical officer to consider this claim? If yes, please provide copies or extract of such reports if you would prefer											
G. CLAIMANT'S PROGNOSIS											
1 What aspect of your patient's disability will prevent him / her from undertaking in any work in the future?											
2 If you feel that the patient could follow a different occupation, can you please give an indication as to the type of work that he / she could undertake.											
3 When do you think the patient will be able to resume working either to his present job or alternative employment?											
H. FURTHER / ADDITIONAL INFORMATION											
1 Please state any information which you feel would be helpful in the assessment of your patient's claim.											
2 Do you have any diagnosis or reports from hospitals or consultants that would help our consultant medical officer to consider this claim? If yes, please provide copies or extract of such reports if you would prefer											
I. DECLARATION											
<p>I hereby declare to the best of my knowledge and belief the foregoing particulars in the reports are true and correct in every aspect.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%;"> <p>-----</p> <p style="text-align: center;">Signature of Medical Officer</p> <p style="margin-top: 20px;">Name of doctor : _____</p> <p style="margin-top: 5px;">Qualification : _____</p> <p style="margin-top: 5px;">Date : _____</p> </div> <div style="width: 45%; text-align: center;"> <p>-----</p> <p style="text-align: center;">Hospital Official Stamp</p> </div> </div>											