

Hospital Cash Treating Doctor's Certificate

Without Prejudice

SBI Life Insurance Company Ltd
Hospital cum Treating Doctor's Certificate

Insured
Member's
recent
photograph

'Part - A' Insured Members Hospitalization Details

Name of the Patient (Insured Member):											
Age of the Patient :			Occupation:								
Address as per Hospital records:											
IP NO:						Total No of days of Hospitalization :					
In Non-ICU Date and time of admission :						Date and time of discharge:					
In ICU Date and time of admission :						Date and time of discharge:					
Exact History reported by the patient at the time of admission:											
*Did the patient take treatment earlier in the Hospital? If yes please provide treatment details:											

***If the space provided is not sufficient for exact history or previous treatment details, please attach sheet.**

'Part - B' Treating Doctor and Hospital's Details

Name of the treating Doctor:														
Address of the Hospital :														
Telephone number:						Email ID :								
Registration Number of the Hospital :						Number of beds in the hospital:								
Date of Registration:						Valid Upto:	D	D	M	M	Y	Y	Y	Y

Tick what is applicable (✓)

Fully equipped operation theatre available	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fully qualified nursing staff under employment 24 hours per day	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Supervised by a fully qualified physician 24 hours per day	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Daily record for hospital patients maintained	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hospital is registered for allopathic treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Certified that the above Insured Member was undergoing treatment in our hospital and the above information is based on the records maintained in the Register No: _____ Entry No _____ dated _____.

Date:

D	D	M	M	Y	Y	Y	Y
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Name of the Doctor: _____

Signature

Stamp of the Hospital