ATTENDING PHYSICIAN'S STATEMENT

PLEASE PRINT

COMPLETE AND SEND COPY TO:
Young Marines National Headquarters
17739 Main Street, Suite 250
Dumfries, VA 22026-3256
Fax: (202) 315-3594
Email: patricia.borka@youngmarines.com

PLEASE SUBMIT INJURY REPORT TO YMNHQ WITHIN 30 DAYS OF ACCIDENT

INJURY REPORT AND ATTENDING PHYSICIAN'S STATEMENT FORMS MUST ACCOMPANY CLAIMS TO BE SUBMITTED TO HSR BY CLAIMANT

PATIENT'S INFORMATION

LAST NAME		FIRST NAME	MIDDLE INITIAL
AGE	BIRTHDATE (MM/DD/YYYY)	SOCIAL SECURITY NUMBER	

HOME ADDRESS
Street City State Zip

PARENT/GUARDIAN NAME	RELATIONSHIP
PRIMARY PHONE	ALTERNATE PHONE

PART I – TO BE COMPLETED BY ATTENDING PHYSICIAN

Complete section below in full or attach a complete itemized statement of charges and statement of diagnosis.

I hereby authorize ***Health Special Risk, Inc.*** or its representative, 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, to make copies of the same or any portion thereof, pertaining to the subject patient.

Attending Physician Signature X	Degree	Date

PART II - STATEMENT OF ATTENDING PHYSICIAN/DENTIST

1. DIAGNOSIS (Describe nature of injury or illness):

_____

_____

_____

2. Is the condition the result of ☐ illness or ☐ injury? (Check appropriate box) What date did the illness commence or injury occur?

3. Has the patient had treatment for the same or related condition before? ☐ YES ☐ NO ☐ Unknown (Check appropriate box)
If YES, when and by whom?

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

Give date(s) 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: _____ Hospital Phone: _____ Dates: (From/To) _____

Hospital Address: _____ City: _____ State: _____ Zip: _____

6. If surgery was performed, please describe:

_____

_____

_____

7. Prognosis:

_____

_____

_____

Physician's Name (Please Print)	Social Security or Tax ID Number

Address of Attending Physician/Dentist
Street City State Zip

Attending Physician's Signature X	Date