To Nanairo Life Insurance Company, Limited

English only: Please type or write in block letters.

MEDICAL CERTIFICATE (Attending physician's statement)

1. Patient's Name (患者氏名) (SURNAME: 姓) / (FIRSTNAME: 名)	Sex (性別)	Patient's Date of Birth (生年月日)
	☐Male (男) ☐Female (女)	/ / Month Day Year

2. Name of Disease and / or Injury (傷病名)

ⅰ. Name of Disease/Injury for Hospitalization (Operation) (傷病名)

Onset Date of Disease/Injury (傷病発生年月日)

Check the box
☐ (Physician's opinion 医師推定)
☐ (Patient's report 患者申告)
/ /
Month Day Year

ⅱ. Etiology (原因)

ⅲ. Complications (合併症)

ⅳ. In case of malignant neoplasm (悪性新生物の場合)

Histopathological diagnosis (病理組織学的診断)			
Date of diagnosis (診断日)	/ / Month Day Year	TNM classification (pTNM)	

3. Period of Medical Treatment (治療期間)

ⅰ. Initial consultation (初診): from / / to / / ☐ Final Consultation (終診) ☐ Under Treatment (加療中)
Month Day Year Month Day Year

ⅱ. Period of hospitalization (入院)

The 1st.	from / / to / / Month Day Year Month Day Year	☐ Discharged (退院) ☐ Inpatient (入院中)
The 2nd.	from / / to / /	☐ Discharged ☐ Inpatient

ⅲ. Date treatment was received as an outpatient (通院): Please circle day(s)

		Total
month /year	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Day(s)
month /year	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Day(s)
month /year	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Day(s)

4. History of present illness (初診までの経過): Please indicate when and how symptom first appeared

Present condition and Clinical course (初診時の所見および経過)

5. Special professional Intervention (特定検査) : Check the box

Type	☐①Cerebral angiography (脳血管カテーテル検査) ☐②Cardiac catheterization (心臓カテーテル検査) ☐③Laparoscopy (腹腔鏡検査) ☐④Thoracoscopy (胸腔鏡検査) ☐⑤Mediastinoscopy (縦隔鏡検査)

Name of Intervention (検査名)	Date of Intervention (検査日) / / Month Day Year
Type of anesthesia	☐①General anesthesia (全身麻酔) ☐②Other anesthesia (その他の麻酔) ☐③None (麻酔なし)

6. Operation (including surgical Intervention) (手術) : Check the box

Type	☐①Craniotomy (開頭術) ☐②Burr hole opening (穿頭術) ☐③Thoracotomy・Thoracoscopic surgery (開胸・胸腔鏡下手術) ☐④Laparotomy・Laparoscopic surgery (開腹・腹腔鏡下手術) ☐⑤Endoscopic surgery (ファイバースコープ手術) ☐⑥Intravascular surgery (血管カテーテル手術) ☐⑦Others( )
Details	☐ In case of skin grafting 25㎠ or above (植皮面積25㎠以上である)

Name of Operation (手術名)	Date of Operation (手術日) / / Month Day Year
Type of anesthesia	☐①General anesthesia (全身麻酔) ☐②Other anesthesia (その他の麻酔) ☐③None (麻酔なし)

7. Radiotherapy (放射線照射)

Part (部位)	Quantity in total (総線量) Gray (Rad)
Period (期間)	from / / to / / Month Day Year Month Day Year
Type of anesthesia	☐①General anesthesia (全身麻酔) ☐②Other anesthesia (その他の麻酔) ☐③None (麻酔なし)

I hereby certify that all the information given is correct.

Date: Month / Day / Year

Name of hospital .....

Address of hospital .....

Country

Signature of doctor .....