To:Rakuten Life Insurance Co.,Ltd.

English Only ; Please type or write in block letters.

PROOF OF HOSPITALIZATION (STATEMENT OF ATTENDING DOCTOR)
入院証明書(診断書)

1. Name of patient (氏名)	2.Date of birth (生年月日)
(Sex ☐ M ☐ F)	____/____/____ Month Day Year
3. Name of sickness or injury for hospitalization (傷病名)	4.Inception date of sickness or injury(傷病発生日)
(☐ Presumption of doctor ☐ Reported by patient)	____/____/____ M D Y

5. Treatment term (治療期間)		
First medical consultation	____/____/____ M D Y	
Dates in hospital	Admitted ____/____/____ M D Y	Discharged ____/____/____ M D Y
Dates in hospital	Admitted ____/____/____ M D Y	Discharged ____/____/____ M D Y

6.Dates of outpatient treatments (通院日)

Month/Year	Date (Circle the dates of outpatient treatment of sickness or injury)	Monthly Total
	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	Days
	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	Days
	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	Days
	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	Days
	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	Days
	Sum total	Days

7. Type of operation(s) performed (手術)

Type of operation

☐ Craniotomy ☐ Thoracotomy ☐ Laparotomy ☐ Operation using a fiberscope or a basket-lip vascular catheter on the brain, larynx, thoracic organs, and abdominal organs (excl. diagnostic procedures and temporary treatment)

☐ Others (   )

Name of operation		Date of operation	____/____/____ M D Y

8. Diagnosis of malignant neoplasm (悪性新生物の場合)

Diagnosis of histopathological examination	Date of diagnosis	TNM Staging	Disclosure to patient
	____ ____ ____ M D Y	T ( ) N ( ) M ( )	☐ Yes ☐ No

9. Radiotherapy (放射線)	Part of treated (部位)		Period (期間)	____/____/____ to ____/____/____ M D Y M D Y
	Amount of radiation in total(総線量)			Gy (Rads)

10. Previous sickness (if any) (既往症(あれば))

Please provide name of sickness,treatment term and any other pertinent information.

These statements are true and complete to the best of my knowledge and belief.

Name of hospital ______________________ Date ____/____/____ M D Y

Address of hospital ______________________

Signature of doctor ______________________ Country ______________________

(610-606-02-1701)