



Fees charged for this statement are to be paid by the claimant.

**A. Information about the deceased**

Last name	First name	Date of birth YYYY-MM-DD
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**B. Physician's statement**

Date of death YYYY-MM-DD	Place of death
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Residence at death - No., street	City	Province	Postal code
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If the deceased died in a hospital or in another institution, give the name:

Age at death: \_\_\_\_\_ OR Date of birth: YYYY-MM-DD

1. Disease or condition directly leading to death (This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury or complication which caused death):	Interval between onset and death
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2. Antecedent causes (morbid conditions, if any, giving rise to the above condition) due to or as a consequence of: (a)	
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(b)	
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3. (a) Other significant conditions (contributing to the death but not related to the disease or condition causing death):	
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(b) Was death related to acquired immunodeficiency syndrome?  Yes  No

4. Date of first attendance in last illness YYYY-MM-DD	5. Date of last attendance in last illness YYYY-MM-DD	6. Date of diagnosis YYYY-MM-DD	7. When was the deceased informed the first time about this illness? YYYY-MM-DD
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8. Was the death due to:  accident  suicide  homicide Describe briefly:

9. Was an inquest held?  Yes  No If yes, by whom and with what findings:

10. Was an autopsy performed?  Yes  No If yes, by whom and with what findings:

11. Have you treated or advised the deceased during the last 3 years, prior to last illness?  Yes  No  
If yes, please furnish the following:

Nature of illness or injury	Hospital or institution	Address	Date
			YYYY-MM-DD
			YYYY-MM-DD

12. Did the deceased, to your knowledge, receive treatment during the last 3 years of his life from any other physician, or in any hospital or institution?  Yes  No  
If yes, please furnish the following:

Nature of illness or injury	Physician, hospital or institution	Address	Date
			YYYY-MM-DD
			YYYY-MM-DD

13. Did the deceased ever use tobacco under any form?  Yes  No

14. When did the deceased start smoking?

15. When did the deceased stop smoking?

16. Specify non-smoking periods:

**C. Physician's identification**

Last name, first name: \_\_\_\_\_ Telephone no.: AREA CODE + NO. \_\_\_\_\_

License no.: \_\_\_\_\_ Fax no.: AREA CODE + NO. \_\_\_\_\_

General practitioner  Specialist  Specify: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_