

# 様式 1 2

Request to Attending Physician 担当医へのお願い

- 1 This form is used for claiming the compensation benefit. この様式は補償給付の申請に使用されます。
- 2 This form should be completed and signed by the attending physician. この様式は担当医が書き、かつ署名して下さい。
- 3 This form is required for each month, separately for hospitalization, outpatient care, and home visit.  
各月毎、入院・入院外毎に付この様式 1 枚が必要です。

## Attending Physician's Statement 診療内容明細書

1. Name of Patient (Last, First) \_\_\_\_\_  
患者名  
Age(Date of Birth) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
年齢 (生年月日)  
Sex(Male・Female) \_\_\_\_\_  
性別 (男・女)
2. Name of Illness 疾病名 : Bronchial asthma and its sequelae 気管支ぜん息及びその続発症
3. Date of First Diagnosis 初診日 : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
4. Days of Diagnosis and Treatment 診療日数 : \_\_\_\_\_ days 日間
5. Type of Treatment 治療の分類  
☐ Hospitalization : From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ ,to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ days)  
入院 自 至 ( 日間)  
☐ Outpatient or Home Visit : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
入院外 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
6. Nature and Condition of Illness (in brief) 症状の概要  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Prescription ,Operation and any other Treatments(in brief) 処方、手術その他の処置の概要  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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8. Itemized Amounts paid to Hospital and / or Attending Physician : Form B

治療実費：様式 B

9. Name and Address of Attending Physician 担当医の名称及び住所

Name 名前：Last 姓 \_\_\_\_\_ First 名 \_\_\_\_\_ Title 称号 \_\_\_\_\_

Office 病院又は診療所： \_\_\_\_\_

Address of Office 病院又は診療所の住所：

\_\_\_\_\_

Date 日付： \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Signature 署名： \_\_\_\_\_

Attending Physician 担当医

To : Mayor of Chiba

あて先 千葉市長

〒 260-8722 Chiba, Chuo-ku, Chiba Minato 1-1

Chiba city hall Environmental Conservation Section

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