



THC000101

Canara HSBC Oriental Bank of Commerce Life Insurance Co. Ltd.

Unitech Trade Centre, 2nd Floor, Sushant Lok, Phase-1, Sector-43, Gurgaon, Haryana, India – 122009

Treating Hospital Certificate

Form – H

Important Information:

- 1. This form is to be completed by the authorities at all the hospitals where the deceased was hospitalized
2. Please attach the patient admission sheet, investigations, history sheet, treatment records along with this form
3. One form is to be filled up per hospital/ nursing home

Please provide the following information based on the medical records and annex supporting documents

Policy no(s) _____

i. Name and Address of the deceased _____

ii. Age at Death ___ years, Occupation _____ Any mark of identification? _____

i. Date of Death ___/___/_____ Time of Death ___:___ (a.m. / p.m.)

ii. Place of Death _____

i. Date and Time of admission ___/___/_____;___:___ (a.m. / p.m.) Admission no. _____

ii. Was the deceased referred by any doctor/ hospital Yes ___ No ___

If yes, then provide with the name and address _____

Contact no. _____

iii. What were the complaints/ condition of the deceased at the time of admission?

iv. What was the exact nature and duration of the illness suffered by the deceased ? (Please enclose admission notes) _____

v. Was the history of illness reported by the patient himself? Yes ___ No ___

If no, then by whom the history was reported _____

vi. Name of the doctor who had recorded the history in the records _____

vii. Did the deceased suffer from any past ailment as disclosed at the time of admission? Yes ___ No ___

If yes, then provide details of the nature of the ailment and its duration _____

(*Annex supporting documents)

viii. What was the diagnosis made at the hospital _____

ix. What were the tests/ investigations undergone by the deceased at the hospital to confirm the diagnosis?

(Please attach separate sheets if required) _____

x. When was the diagnosis confirmed at the hospital?



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xi. What was the treatment given to the deceased during the hospitalization?

xii. Was/ were there any other contributory illnesses/ chronic ailments suffered by the deceased that existed at the time of admission? Yes No

If yes, detail _____

xiii. What was the date of discharge from the hospital? //

xiv. What was the condition of the deceased at the time discharge?

xv. Was the deceased treated at the hospital at any other occasion as an out-patient or inpatient? Yes No

If yes, please provide details _____

xvi. Was the deceased treated by any other medical practitioner/hospital during the past 3 years? Yes No

If yes then provide the details:

Name	Address	Contact No.

Certified that the above information is correct as per hospital records:

Date: / Place _____

Signature: _____

Name and Designation of the Doctor: _____

Qualifications and code of the Doctor: _____

Name of the Hospital: _____

Registration Number of the Hospital: _____

Address: _____

Telephone Number _____

Seal / Stamp of the Hospital: _____

(Mandatory)