Physician's Form for Trip Cancellation Coverage

Date of accident, injury or illness: ____/____/____ (MM/DD/YY)
Date of first treatment or onset: ____/____/____ (MM/DD/YY)
Please describe the nature of the patient's injuries or illness:

_____

_____

_____

Was this a referral from another doctor? YES / NO If yes, date of referral: ____/____/____

Was the patient hospitalized? YES / NO
If yes, please list the names and location of all hospitals and all admission/discharge dates.

Hospital Name	Location	Adm. Date	Dis. Date
_____	_____	_____	_____
_____	_____	_____	_____

Was the patient recommended by you to curtail their trip/travel due to this condition? YES / NO
If yes, travel restriction dates advised: ____/____/____ to ____/____/____

Did this travel restriction affect any other family members or travel companions? YES / NO
If yes, why did family member/travel companion need to curtail their travel?

_____

_____

Did the patient have any condition (including pregnancy) prior to trip booking that contributed to their present condition? YES / NO
If yes, please describe: _____

_____

For pregnancy: EDC: _____
If yes, at what date did patient originally begin treatment with this previous condition:

_____

If yes, was the patient's previous condition stable at least 60 days prior to booking the trip? YES / NO
Please describe: _____

_____

_____ _____ _____

Physician's Name **Signature** **Date**