Form A
様式 A

1. This form is used for claiming the social insurance benefit.
   この様式は社会保険の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. One form for each month, one form for hospitalization/outpatient and home visit.
   各月毎，入院・入院外毎に付この様式が1枚必要です。

Attending Physician's Statement
診療内容明細書

1. Name of patient(Last, First) Age(Date of Birth) Sex(Male · Female)
   患者名 _____ 年令(生年月日) _____ 性別 (男・女)
2. Name of Illness or Injury preferably with Number of International Classification of Diseases for the use of Social Insurance (See the other side of this form)
   傷病名及び社会保険表章用国際疾病分類番号 (裏面参照)
3. Date of First Diagnosis : _____ , 20____
   初診日
4. Days of Diagnosis and Treatment : _____ days
   診療日数
5. Type of Treatment
   治療の分類
   ☐ Hospitalization : From _____ , 20____ to _____ 20____ (days)
   入院 自 至 (日間)
   ☐ Out patient or Home Visit : _____ , 20____ _____ , 20____
   入院外 _____ , 20____ _____ , 20____
6. Nature and Condition of Illness or Injury (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
8. Was the treatment required as a result of an accidental injury ? Yes ☐ No ☐
   治療は事故の傷害によるものですか。 はい いいえ
9. Itemized amounts paid to Hospital and/or Attending physician : Form B
   治療実費 様式 B
10. Name and Address of Attending Physician
    担当医の名前及び住所
    Name 名前 : Last 姓 First 名
    Address 住所 : Home 自宅 Phone
    Office 病院又は診療所 Phone

Date 日付 _____ Signature 署名

Attending Physician 担当医

Reference Number of your Medical Record (if applicable)
診療録の番号 _____