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 either the attending physician or the superintendent of a hospital / clinic.
この様式は担当医が書き、かつ署名してください。
3. One form for each month, One form for hospitalization / outpatient and home visit.
各月ごと、入院・入院外ごとに付きこの様式1枚が必要です。

Form A
様式 A

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 年齢 性別 （男・女）
2. Name of Illness or Injury preferably with Number of International Classification of Diseases for the use of Social Insurance.
傷病名及び社会保険用国際疾病分類番号
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
     入院自 至
   - ☐ 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