SWISS RELIEF SOCIETY—NASHVILLE, TENN.

CLAIM FOR ILLNESS OR INJURY

TO THE PHYSICIAN: Please fill out!

1. Name of Patient: ______________________ Age: ______
2. Address: Street ______________ No. ____ City ____________
3. Name of Disease or Desription of Injury: ______________________
4. Give date of first visit or treatment for this disability or injury: ____________
5. Date of last visit or treatment: ______________________
6. Is disease of chronic form? ______________________
7. How long, in your opinion, has patient been affected with the present disease?
8. Is patient unable to work? ______________________
9. Approximate date when patient will be able to resume work: ____________

Remarks: ______________________

Date ______________ Signed: ______________________ MD

Physicians Address: ______________________