



University of California, Santa Barbara
Attending Physician's Statement
 Proof of Loss Off-Campus/Medical Reimbursement for Accident or Sickness

INSTRUCTIONS

The UC Group Leader must provide the Attending Physician's Statement to the treating doctor to report treatment provided to and costs incurred as the result of any injury or illness contracted by an eligible UCSB student while involved in a covered activity. Submit completed form to UCSB Risk Management.

TREATING PHYSICIAN

Name of Treating Physician: _____ Date of Report: _____

Name of Company or Hospital: _____

Address: _____

Work Ph: _____ Home Ph: _____ Email: _____

INJURED STUDENT

Name of Injured Student: _____ Gender: Male Female

Address: _____ Birthdate: _____

Work Ph: _____ Home Ph: _____ Email: _____

INJURY/ILLNESS

Date of accident: _____ When did patient first consult you? _____ Date first treated: _____

When, where & how do you understand accident/illness occurred?

Nature and extent of injuries (state objective findings and describe complications, if any):

Diagnosis:

What operation or operative procedure was performed (if any)?

Total amount of your fee for services rendered (please attached itemized billing): _____

REPORT BY

Report by: _____ Title: _____

Signature: _____ Ph: _____ Date: _____