



**TAKAFUL IKHLAS FAMILY BERHAD** Registration No. 200201025412 (593075-U)

IKHLAS Point, Tower 11A, Avenue 5, Bangsar South,

No. 8, Jalan Kerinchi, 59200 Kuala Lumpur

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**KENYATAAN PEGAWAI PERUBATAN (KEMATIAN)**  
**ATTENDING PHYSICIAN STATEMENT (DEATH)**

**Peringatan / Reminders :**

- 1 Borang ini hendaklah diisi oleh Pegawai Perubatan bertauliah yang memberi rawatan terakhir kepada si mati.  
*This form must be completed by the certified Medical Officer who had attended to the deceased during the last illness*
- 2 Segala perbelanjaan untuk mendapatkan laporan ini adalah menjadi tanggungan penuntut.  
*Any cost incurred in relation to this report is borne by the claimant*

**NO. SIJIL / CERTIFICATE NO.**

**A. BUTIRAN KEMATIAN PESERTA / PARTICIPANT'S DEATH DETAILS**

- 1 Nama penuh si mati / Deceased's name in full : \_\_\_\_\_
- 2 No. Kad Pengenalan/ NRIC No. : Baru/ New : \_\_\_\_\_ Lama/ Old : \_\_\_\_\_
- 3 Alamat semasa kematian : \_\_\_\_\_  
*Residence at time of death :* \_\_\_\_\_  
Poskod / Postcode \_\_\_\_\_ Bandar / Town \_\_\_\_\_  
Negeri / State \_\_\_\_\_
- 4 Tempat kematian : \_\_\_\_\_  
*Place of death :* \_\_\_\_\_
- 5 Tarikh kematian : \_\_\_\_\_ 6 Berapa umur si mati? \_\_\_\_\_ Tahun: \_\_\_\_\_  
*Date of death :* HH/DD BB/MM TT/YY *What was the age of the deceased?* \_\_\_\_\_ *Years:* \_\_\_\_\_

**B. MAKLUMAT PERUBATAN / MEDICAL INFORMATION**

- |  |  |              |                           |  |                        |                   |                           |  |                        |        |                        |  |                           |  |                        |
|--|--|--------------|---------------------------|--|------------------------|-------------------|---------------------------|--|------------------------|--------|------------------------|--|---------------------------|--|------------------------|
| 1 Berapa lamakah anda telah mengenali simati?<br><i>How long have you known the deceased?</i>  |  |              |                           |  |                        |                   |                           |  |                        |        |                        |  |                           |  |                        |
| 2 Berapa lamakah anda telah merawat dan menjadi penasihat kepada si mati? Jika ya, nyatakan nama penyakit, jenis rawatan serta tarikh rawatan.<br><i>How long have you been the medical attendant or advisor for the deceased? If yes, please state the diagnosis, treatment given and the date of consultation</i>  |  |              |                           |  |                        |                   |                           |  |                        |        |                        |  |                           |  |                        |
| 3 a. Tarikh lawatan pertama si mati. Nyatakan untuk penyakit apa.<br><i>Date of deceased's first visit. Please state the illness.</i><br>b. Tarikh lawatan terakhir si mati. Nyatakan untuk penyakit apa.<br><i>Date of deceased's last visit. Please state the illness.</i>   | <table><tr><td>HH/DD</td><td>BB/MM</td><td>TT/YY</td></tr><tr><td>HH/DD</td><td>BB/MM</td><td>TT/YY</td></tr></table>  | HH/DD        | BB/MM                     | TT/YY  | HH/DD                  | BB/MM             | TT/YY                     |  |                        |        |                        |  |                           |  |                        |
| HH/DD  | BB/MM  | TT/YY        |                           |  |                        |                   |                           |  |                        |        |                        |  |                           |  |                        |
| HH/DD  | BB/MM  | TT/YY        |                           |  |                        |                   |                           |  |                        |        |                        |  |                           |  |                        |
| 4 Adakah anda merawat si mati semasa sakitnya yang terakhir? Jika ya, untuk penyakit apa?<br><i>Did you attend to the deceased during his last illness? If yes, for what disease?</i>  | <input type="checkbox"/> Ya <input type="checkbox"/> Tidak<br>Yes No   |              |                           |  |                        |                   |                           |  |                        |        |                        |  |                           |  |                        |
| 5 a. Apakah punca utama kematian tersebut?<br><i>What was the immediate cause of death?</i><br>b. Apakah simptom terhadap punca kematian tersebut.<br><i>What were the symptom(s) leading towards the death?</i><br>c. Menurut simati, berapa lama beliau telah mengalami simptom tersebut sebelum menemui anda?<br><i>According to the deceased, how long had he / she been experiencing these symptoms before seeing you?</i><br>d. Pada pendapat anda, berapa lamakah simptom tersebut telah wujud?<br><i>How long do you feel the symptom(s) had lasted?</i> |  |              |                           |  |                        |                   |                           |  |                        |        |                        |  |                           |  |                        |
| 6 a. Adakah pesakit menghidapi penyakit-penyakit lain i.e. Diabetes, Mellitus, darah tinggi atau masalah jantung? Jika Ya, sila nyatakan sejak bila. (dd/mm/yyyy)<br><i>Did the deceased suffer from any other illness? i.e. Diabetes, Mellitus, Hypertension atau heart disease?</i><br>b. Jika ya, sila nyatakan penyakit-penyakit tersebut dan sejak bila.<br><i>If yes, please state the illness and duration of illness.</i>  | <p><i>* If 'YES', please state the illness and date of first diagnosed</i></p> <table><tr><td>Hypertension</td><td>Date 1st diagnosed: _____</td></tr><tr><td><input type="checkbox"/> Ya <input type="checkbox"/> Tidak<br/>Yes No</td><td>Place diagnosed: _____</td></tr><tr><td>Diabetes Mellitus</td><td>Date 1st diagnosed: _____</td></tr><tr><td><input type="checkbox"/> Ya <input type="checkbox"/> Tidak<br/>Yes No</td><td>Place diagnosed: _____</td></tr><tr><td>Others</td><td>Name of illness: _____</td></tr><tr><td><input type="checkbox"/> Ya <input type="checkbox"/> Tidak<br/>Yes No</td><td>Date 1st diagnosed: _____</td></tr><tr><td></td><td>Place diagnosed: _____</td></tr></table> | Hypertension | Date 1st diagnosed: _____ | <input type="checkbox"/> Ya <input type="checkbox"/> Tidak<br>Yes No | Place diagnosed: _____ | Diabetes Mellitus | Date 1st diagnosed: _____ | <input type="checkbox"/> Ya <input type="checkbox"/> Tidak<br>Yes No | Place diagnosed: _____ | Others | Name of illness: _____ | <input type="checkbox"/> Ya <input type="checkbox"/> Tidak<br>Yes No | Date 1st diagnosed: _____ |  | Place diagnosed: _____ |
| Hypertension   | Date 1st diagnosed: _____  |              |                           |  |                        |                   |                           |  |                        |        |                        |  |                           |  |                        |
| <input type="checkbox"/> Ya <input type="checkbox"/> Tidak<br>Yes No   | Place diagnosed: _____   |              |                           |  |                        |                   |                           |  |                        |        |                        |  |                           |  |                        |
| Diabetes Mellitus  | Date 1st diagnosed: _____  |              |                           |  |                        |                   |                           |  |                        |        |                        |  |                           |  |                        |
| <input type="checkbox"/> Ya <input type="checkbox"/> Tidak<br>Yes No   | Place diagnosed: _____   |              |                           |  |                        |                   |                           |  |                        |        |                        |  |                           |  |                        |
| Others   | Name of illness: _____   |              |                           |  |                        |                   |                           |  |                        |        |                        |  |                           |  |                        |
| <input type="checkbox"/> Ya <input type="checkbox"/> Tidak<br>Yes No   | Date 1st diagnosed: _____  |              |                           |  |                        |                   |                           |  |                        |        |                        |  |                           |  |                        |
|  | Place diagnosed: _____   |              |                           |  |                        |                   |                           |  |                        |        |                        |  |                           |  |                        |

<p>c. Adakah sebarang penyiasatan, ujian atau prosedur dijalankan? Jika ya, sila nyatakan maklumat lanjut atau salinan keputusan ujian asal yang disahkan. <i>Had any investigation, tests or procedures been performed? If yes, please furnish us the details or certified true copy of the results.</i></p>									
<p>7 Berapa lamakah si mati berada di rumah atau terhalang daripada bekerja sebelum kematiannya? <i>For how long was deceased confined to the house or prevented from attending to his / her business?</i></p>									
<p>8 a. Adakah sebab-sebab tertentu berlakunya kematian, samada secara langsung atau tidak yang diakibatkan oleh amalan, pekerjaan atau kediaman si mati? Jika ya, sila terangkan. <i>Was there any special cause, directly or indirectly, for the death in the habits, occupation or residence of the deceased? If yes, please specify.</i></p> <p>b. Adakah kematian ini ada kaitan dengan penyakit HIV, AIDS, atau berkaitan dengannya? <i>Was the cause of death due to HIV, AIDS or related disease?</i></p> <p>c. Jika ya, apakah punca asal mendapat penyakit tersebut? (e.g. blood transfusion, STD, etc.) <i>If yes, what is the cause of the disease (e.g. blood transfusion, STD, etc.)</i></p>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <input type="checkbox"/> Ya Yes         </div> <div style="text-align: center;"> <input type="checkbox"/> Tidak No         </div> </div>								
<p>9 Adakah si mati menggunakan alkohol atau narkotik? <i>Did the deceased consume alcohol or narcotics?</i></p>									
<p>10 Sila beri nama dan alamat semua pakar dan pengamal perubatan di mana di dalam pengetahuan anda telah merawat si mati dalam masa tiga tahun yang lalu. <i>Give names and addresses of all physicians and other practitioners who to your knowledge had attended to the deceased during the past three years.</i></p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Nama / Name</th> <th style="width: 25%;">Alamat / Address</th> <th style="width: 25%;">Penyakit / Diagnosis</th> <th style="width: 25%;">Tarikh / Date</th> </tr> </thead> <tbody> <tr> <td style="height: 40px;"></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Nama / Name	Alamat / Address	Penyakit / Diagnosis	Tarikh / Date				
Nama / Name	Alamat / Address	Penyakit / Diagnosis	Tarikh / Date						
<p>11 Jika helaian borang ini tidak mencukupi, sila tulis di lampiran lain dan hantarkan bersama borang ini. <i>If the form is not sufficient to write all the information, please add paper and submit together.</i></p>									
<b>C. MAKLUMAT PEGAWAI PERUBATAN / PHYSICIAN DETAILS</b>									
<p>1 a. Berapa lamakah anda telah bekerja sebagai pakar perubatan? <i>How long have you practiced as a physician?</i></p> <p>b. Dimanakah anda menerima pengajian perubatan anda dan bila? <i>Where did you received your medical education and when?</i></p>									
<b>D. PENGAKUAN / DECLARATION</b>									
<p>Saya, penandatangan di bawah, di sini mengaku bahawa saya adalah doktor yang mengendalikan sakit terakhir Tuan / Puan / Cik _____ yang dilindungi oleh Takaful Ikhlas Sdn Bhd di bawah No. Sijil _____ dan setiap keterangan-keterangan yang diberikan adalah benar di dalam pengetahuan dan kepercayaan saya.</p> <p><i>I, the undersigned, hereby declare that I was the doctor in attendance during the last illness of Mr / Mrs / Miss _____ who was insured with Takaful Ikhlas Sdn Bhd under the Certificate no. _____ and those of the foregoing answers are true to the best of my knowledge and belief.</i></p> <div style="display: flex; justify-content: space-between; margin-top: 50px;"> <div style="width: 45%;"> <p>_____</p> <p>Tandatangan Pegawai Perubatan <i>Signature of Medical Officer</i></p> </div> <div style="width: 45%; text-align: center;"> <p>_____</p> <p>Cop Rasmi Hospital <i>Hospital Official Stamp</i></p> </div> </div> <div style="margin-top: 20px;"> <p>Nama doktor / Name of doctor : _____</p> <p>Kelulusan / Qualification : _____</p> <p>Tarikh / Date : _____</p> </div>									