To: Waseda University

Medical Treatment report

Indemnitee (person injured)		Birth date Sex M W seal	Application date:
Compensation claimant	As above If the injured party is a minor (under 20) his or her parent or guardian need to write down in this section		Relationship with the indemnitee : 1. Self 2. Parent or guardian 3.Other
Time and date of accident	Y M D Time :		
Condition of Injury	Bruise Cut Graze Rupture Cutting Burn Other Sprain Dislocation Fracture fixation apparatus in use (Plastic cast Splint Other) Terms of its use (Y M D〜 Y M D)		
Part of body injured	Head Face Neck Body Please describe injured part specifically in the below ( )	Upper Limb: Arm Part______ left right ______Finger left right	Lower Limb: Leg Part______ left right ______Toe left right

Period of visiting hospital	From Y M D To Y M D Total ( ) Days (of which, the total days you actually went to the hospital or clinic ( ) days)	Please circle dates when you went to a hospital or clinic. ≪Case of visit to several hospitals≫ Please describe a visit of first hospital with” ○”mark and second one with” □”mark.
Period of absence by injury	From Y M D To Y M D	
Period till you recover fully.	From Y M D To Y M D	

M	1	2	3	4	5	6	7	8	9	10	
	11	12	13	14	15	16	17	18	19	20	
	21	22	23	24	25	26	27	28	29	30	31
M	1	2	3	4	5	6	7	8	9	10	
	11	12	13	14	15	16	17	18	19	20	
	21	22	23	24	25	26	27	28	29	30	31
M	1	2	3	4	5	6	7	8	9	10	
	11	12	13	14	15	16	17	18	19	20	
	21	22	23	24	25	26	27	28	29	30	31
M	1	2	3	4	5	6	7	8	9	10	
	11	12	13	14	15	16	17	18	19	20	
	21	22	23	24	25	26	27	28	29	30	31
M	1	2	3	4	5	6	7	8	9	10	
	11	12	13	14	15	16	17	18	19	20	
	21	22	23	24	25	26	27	28	29	30	31
M	1	2	3	4	5	6	7	8	9	10	
	11	12	13	14	15	16	17	18	19	20	
	21	22	23	24	25	26	27	28	29	30	31
M	1	2	3	4	5	6	7	8	9	10	
	11	12	13	14	15	16	17	18	19	20	
	21	22	23	24	25	26	27	28	29	30	31

Please write down the items of your patient card below(Or please attach the copy of the card in case you went to several hospitals)

Hospital :

The place of hospital : ________________

Tel : ________________

Treatment department : Surgery Orthopedics department Other( )

(Note 1) In case the amount of a request for the claim is less than ¥100,000, Please write down a medical treatment report and attach a copy of patient card or receipt. That is substitute for Treatment report.