Avo Insurance Company Limited
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Avo Domestic Helper Protection
Avo 家傭保障

Claim Form 索償申請表

Please complete this Claim Form in Block Letters and provide all supporting documents to the Company within 30 days after the incident occurred to avoid delay in claim process. The Company is entitled to request for further information, documents or other specific claim form to be completed, and assign a loss adjuster for investigation. Completion and submission of this Claim Form shall not be construed as admission of liability on the part of the Company.

請以正楷填妥並簽署此索償申請表，連同有關證明文件於事件發生後30天內交回本公司，以免延誤索償進程。本公司有權要求索償人 / 保單持有人提供更多資料、文件或填寫其他專用索償表格，以及委派公證行人員進行調查。填寫及遞交此索償申請表並不表示本公司承擔賠償責任。

Policy Holder Personal Details 保單持有人個人資料	
Policy No.: 保單號碼：	Name of Policy Holder: 保單持有人姓名：
Mobile Phone Number: 流動電話號碼：	Email Address: 電郵地址：
Correspondence Address: 通訊地址：	

Insured Person Personal Details 受保人個人資料
Name of Insured Person: 受保人姓名：
HKID No. & / or Passport No.: 香港身份證號碼及 / 或護照號碼：

Claims Payment Method (The request for payment method is not an admission of our liability) **賠償支付方式（本公司特此聲明此項要求並不代表本公司承認賠償責任）**			
☐	Cheque 支票		
☐	FPS 轉數快 FPS registered Mobile Number / E-mail / ID: 轉數快註冊的電話號碼、電郵地址、轉數快識別碼：___________		Payee's Name: 收款人姓名：___________
☐	Bank Autopay 銀行自動轉賬 Bank Name: 銀行名稱：___________		Payee's Name: 收款人姓名：___________
	Bank Code: 銀行編號：___________	Branch Code: 分行編號：___________	Bank A/C No.: 銀行帳戶號碼：___________

General Information 一般事項			
Is there any other sources / insurance covering the loss / damage? **If "Yes", please submit your claim to the other sources / insurance company before proceeding to us and provide the following information** 閣下是次索償申請之損失 / 損毀是否同時受其他保險或從其他來源獲得保障？如「是」，你應先向其他來源 / 保險公司提出索償並提供以下資料 ☐ Yes 是 ☐ No 否			
(a)	Name of the other sources / insurance company: 保險公司 / 其他來源名稱：	(b)	Amount claimed: 索償金額：
(c)	Relevant policy and claim number: 有關保單及索償檔案號碼：		

Insured Person's Medical Expenses 受保人醫療費用

Please ☑ the applicable option(s) 請在索償項目空格內填上☑號 （可選多項） ☐ Inpatient Expenses 住院費用 ☐ Out-patient Expenses 門診費用 ☐ Dental Expenses 牙科費用	Date and time of incident (DD/MM/YYYY, hh:mm): 事件發生日期及時間（日/月/年，時：分）：

Date of Treatment 治療日期	Diagnosis 診斷結果	Claim amount (HKD) 索償金額（港元）

Other Accident Details 其他意外詳情

Please ☑ the applicable option(s) 請在索償項目空格內填上☑號 （可選多項） ☐ Employer's Liability 僱主責任 ☐ Personal Accident 人身意外 ☐ Service Interruption 服務中斷 ☐ Repatriation 送返回國 ☐ Replacement 補聘家傭 ☐ Personal Liability 個人責任 ☐ Fidelity Protection 忠誠保障 ☐ Family Member Medical Expenses 家庭成員醫療費用保障	Date and time of accident (DD/MM/YYYY, hh:mm): 意外日期及時間（日/月/年，時：分）： Place of accident: 意外發生地點： Claim amount: 索償金額

Full description of accident:
請詳述事故的始末：

Particulars of loss / injuries (please describe injury part and severity)
損失 / 受傷詳情（請描述受傷部位及嚴重程度）

If the accident has been reported to the police, please provide the following:
如有報警，請提供以下資料：

Name of Police Station:
報案警署名稱：

Police Report no:
警方檔案編號：

Name, contact number and address of the third-party claimant and other involved parties:
要求索償的第三者或有關人士的姓名、聯絡電話及地址：

Extent of injury / damage caused with estimate on quantum if possible:
請提供第三者的損失 / 傷亡程度及在可能情況下提供第三者索償的約數：

Has formal claim been received from the third party claimant? 閣下有否正式收到第三者之索償要求？

☐ Yes 有 ☐ No 沒有

***IMPORTANT – Please furnish us with all correspondence directly relating to the third party claim and do not admit any liability to the third party.**
***重要事項 – 如收到第三者的索償信件，請勿私下作出回覆。閣下必須將該等信件呈交本公司。**

Authorization and Declaration 授權及聲明

I/We hereby authorize any hospital, physician, police, person, party and/or authority that has any records or is holding any information of the insured person or me /us to disclose to Avo Insurance Company Limited ("the Company") or its authorized representative, any and all information with respect to the insured person's or my/our loss, disability, medical history, police statement made and the like for the purpose of assessing my/our claim request(s). A photocopy of this authorization shall have the same effect as the original.
I/We hereby declare that all the above information and particulars given herein are accurate, true and complete and are given to the best of my/our knowledge and belief.
I/We have not withheld any material information and acknowledge that failure to supply true and accurate answers to this request or inform the Company of all material information may render the Company unable to accept or process this request and all rights to recover under the Policy shall be forfeited. I/We understand that the issuance or completion of this application does not constitute admission of liability or guarantee payment of the claim on behalf of the Company.
I/We confirm having read and understand and agreed to all the Declarations, terms and conditions and the Company's Personal Information Collection Statement as accompanied with this form.
本人 / 我們謹此授權任何持有受保人或本人 / 我們之任何記錄或資料的醫院、醫生、警方、人士、有關人等、及 / 或有關當局，向安我保險有限公司（「貴公司」）或其授權代表提供任何或所有有關受保人或本人 / 我們之損失、損傷、病歷、口供或任何相關資料作評估賠償申請之用途。此授權書之正本及副本皆具同等效力。
本人 / 我們謹此聲明，上述所有問題的答案包括所有資料及細節均是準確無誤，真實及為事實之全部，並且是盡本人 / 我們所知及所信而作答的。
本人 / 我們並沒有隱瞞任何重要資料及確認如未能提供真實及準確無誤之資料或通知貴公司任何有關此索償申請之重要資料，將可能導致貴公司不能接受或處理此索償申請及喪失所有追討保單權益之權利。本人 / 我們明白此索償申請表之發出及填妥並不代表貴公司承擔責任或保證賠償。
本人 / 我們確認已閱讀及明白並同意所有聲明、條款及細則及隨本表格附上有關貴公司的收集個人資料聲明。

Signature of Claimant / Insured Person: 索償人 / 受保人簽署：	Date (DD/MM/YYYY): 日期（日 / 月 / 年）：

Personal Information Collection Statement 收集個人資料聲明

It is the policy of Avo Insurance Co., Ltd. ("Avo Insurance") to safeguard and keep confidential the personal data of all our customers. Avo Insurance shall at all times observe and ensure our staff strictly adhere to all the requirements under the Personal Data (Privacy) Ordinance ("the Ordinance").

1. Personal Data collected and/or held by Avo Insurance
   Personal data such as first name, last name, HKID Card, date of birth, email address, telephone number, policy number, medical and health records, and question or comment will be collected by us when you make enquires or submit any forms for products or services provided by Avo Insurance.
2. Importance of Personal Data Collection
   From time to time, you will be requested to provide your personal data to Avo Insurance. Provision of personal data to Avo Insurance by you is voluntary. However, Avo Insurance may not be able to provide or continue to provide products and services to you if you fail to provide your personal data as requested by us.
3. Purposes of Personal Data Collection and Usage
   Your personal data held by Avo Insurance may be used for the following purposes:-
   a. Administration of insurance or reinsurance related business, which include underwriting, processing and evaluation of applications, identity and credit checking, suitability checking, policy servicing, claims processing, investigation, account/debt collection, litigation, communications, preparing statistics, data analysis and research, internal and external audit, maintaining quality services, sales and marketing;
   b. Avo Insurance will collect, use and disclose my personal information (including claims history) for the purposes necessary to process my application, investigate and settle claims and detect and prevent fraud (whether or not relating to the policy issued in respect of this application);
   c. Make disclosure to any applicable regulators, governmental bodies or industry recognized bodies as required by any law, rule, regulation, code of practice or guideline, binding on Avo Insurance or our affiliates including without limitation the laws and regulatory requirements of Hong Kong SAR.
4. Personal Data Confidentiality
   The personal data you provide to Avo Insurance will be kept confidential, except that it may be shared with following parties:-
   a. Avo Insurance will transfer personal information to the following persons who may collect and use this information only as reasonably necessary to carry out the purposes described above: insurance adjusters, agents and brokers; employers; health care professionals; hospitals; accountants; financial advisors; solicitors; organisations that consolidate claims and underwriting information for the insurance industry; fraud prevention organisations; other insurance companies (whether directly or through fraud prevention organisation or other persons named in this paragraph), the police and databases or registers (and their operators) used by the insurance industry to analyse and check information provided against existing information;
   b. any subsidiary, holding company, associated company or affiliates of Avo Insurance for any of the purposes set out in section 3a and b;
   c. Any agent, contractor or third party service provider, including but not limited to providers of risk intelligence, loss adjustors, private investigators, letter shopping service providers and debt collectors who provides administrative, telecommunications, computer, internet, payment or other services to Avo Insurance for any of the purposes set out in section 3a;
   d. Any actual or proposed reinsurers of Avo Insurance for any of the purposes set out in section 3a;
   e. Any co-branding partners and our business partners for any of the purposes set out in section 3a and b; and
   f. Any person to whom Avo Insurance is under an obligation to make disclosure under the requirement of any law or regulation binding on or applicable to Avo Insurance or any of our group companies.
5. Personal Data Access / Correction Request
   a. You have the right to check whether Avo Insurance holds personal data about you and of access to and correction of your personal data.
   b. Avo Insurance has the right to charge a reasonable fee for the processing of any personal data access request.
   c. Requests shall be made in writing to our Personal Data Protection Officer, Avo Insurance Company Limited, Unit 3701, 3705-6, 37/F, 118 Connaught Road West, Sheung Wan, Hong Kong.

6. We reserve the right to change this Statement.

維護和保密所有客戶的個人資料是安我保險有限公司（「本公司」）的政策。本公司會一直遵守和確保員工嚴格遵守《個人資料（私隱）條例》(「條例」) 的所有規定。

1. 本公司所收集及 / 或持有的個人資料
   在閣下查詢或提交由本公司提供的產品或服務的表格時，本公司將會收集個人資料如姓名、身份證、出生日期、電郵地址、電話號碼、保單號碼、醫療及健康紀錄、以及問題或意見。
2. 個人資料收集的重要性
   本公司會不時地要求提供閣下的個人資料。向本公司提供閣下的個人資料是自願的。若閣下沒有按照本公司的要求提供該等資料，可能會令本公司無法向閣下提供或繼續提供保險產品及服務。
3. 個人資料收集和使用的目的
   閣下的個人資料可能會用於以下目的：-
   a. 保險管理或再保險業務有關的用途，其中包括承保、處理和評估申請、身份和信用檢查、適用性檢查、保單服務、理賠處理、調查、賬戶 / 債務追收、訴訟、通訊、編制統計、數據分析和研究、內部 / 外界審計、保持優質的服務、銷售和營銷；
   b. 安我保險有限公司將收集、使用和披露我的個人資料（包括以往申索紀錄），以用作處理我的申請、調查和解決申索、以及偵測和防止欺詐行為（無論是否與就此申請而發出的保單有關）所需的目的。
   c. 在對本公司或其附屬機構具有約束力的任何法律、法規、規例、實務守則或指引的要求下（包括但不限於香港法例及監管的要求），向任何適用的監管機構、政府機構或相關行業的認可機構進行披露。
4. 個人資料保密
   本公司會對閣下的個人資料加以保密，但可能會與下列各方透露該等資料：-
   a. 安我保險有限公司將把個人資料轉移給以下人士，而他們只能在有合理需要履行上述目的之情況下才可收集和使用這些資料：保險理算人、代理和經紀；僱主；醫護專業人士；醫院；會計師；財務顧問；律師；整合保險業申索和承保資料的組織；防欺詐組織；其他保險公司（無論是直接地，或是通過防欺詐組織或本段中指名的其他人士）；警察；和保險業就現有資料而對所提供的資料作出分析和檢查的數據庫或登記冊（及其運營者）；
   b. 任何本公司的附屬公司、控股公司、聯營公司或聯屬公司作在第3a和b段中所列出的任何用途；
   c. 任何本公司的代理人、承包商或會向本公司提供行政、電訊、電腦、網際網路、付款或其他服務的第三方服務供應商（包括但不限於風險分析顧問、公證行、私人調查員、信函裝封服務機構及財務公司） 作在第3a段中所列出的任何用途；
   d. 任何本公司的實際或建議再保險公司作在第3a段中所列出的任何用途；
   e. 任何品牌合作伙伴及本公司生意伙伴作在第3a和b段中所列出的任何用途；及
   f. 在對本公司或其任何集團公司具有約束力或適用性的任何法律或法規的要求下而使本公司有責任對其進行披露的任何人士。
5. 個人資料的查閱 / 改正要求
   a. 閣下有權查詢本公司是否持有關於閣下的個人資料及查閱這些資料及改正不準確的資料；
   b. 本公司有權就處理任何個人資料查閱要求收取合理的費用；
   c. 有關要求須以書面提交香港上環干諾道西118號37樓1、5-6室安我保險有限公司的個人資料保護主任。
6. 我們保留更改本聲明的權利。

(If any conflict or inconsistency between the English and Chinese versions, the English version shall prevail. 中文譯本內容如與英文本有歧異，一概以英文為準。)

Appendix: Checklist for Claim Items Documentation
附錄：索償項目文件清單

Claim Items 申請索償項目	Claim Documents Checklist 索償文件清單
Employer's Liability 僱主責任	
Employer's Liability 僱主責任	✦ **You are reminded to report the case to Labour Department by completing and submitting TWO ORIGINAL of respective form within 7 days (for death cases) or 14 days (for injury / occupational disease) from the accident date and do not make any promise or pay for any claim against you nor admit liability thereof without our consent; All writs, summons, letters or communications regarding any such claim must be sent to us immediately unanswered.** **請謹記於意外發生後的7天內（死亡個案）或14天內（受傷或職業性疾病個案）向勞工處遞交2份相關事項的表格正本呈報個案並切勿未經本公司同意，對第三者作出任何法律責任承諾，或同意任何賠償；任何令狀、傳票、書信或通訊皆不須作出回覆，應立即郵寄到本公司作進一步處理** ✓ Copy of Form 2 / 2A / 2B / 5 / 7 (obtaining from Labor Department) 表格2 / 2A / 2B / 5 / 7 副本（於勞工處取得） ✓ Original sick leave certificate(s) 病假證明書正本 ✓ Original medical receipt(s) (if any) 醫療費用收據正本（如有） ✓ Copy of employment contract 僱傭合約副本 ✓ Copy of salary paid records for past 6 months 過去6個月的薪酬支付紀錄副本 ✓ Original Letter of Authorization signed by Insured Person for medical record 受保人簽署的授權書正本以索取醫療紀錄
Insured Person's Medical Expenses 受保人醫療費用	
Inpatient Expenses 住院費用	✓ Original of medical receipts with diagnosis 註有病症診斷的醫療費用收據正本 ✓ Copy of letter of hospital admission and discharge summary 入院紙及出院紙副本 ✓ Copy of full medical report 詳細醫療報告副本 ✓ Copy of Police Statement for the accident (if applicable) 所有警方口供紙副本（如適用） ✓ Original sick leave certificate(s) 病假證明書正本 ✓ Original Letter of Authorization signed by Insured Person for medical record 受保人簽署的授權書正本以索取醫療紀錄
Out-patient Expenses 門診費用 Dental Expenses 牙科費用	✓ Original of medical receipts with diagnosis 註有病症診斷的醫療費用收據正本 ✓ Copy of Police Statement for the accident (if applicable) 所有警方口供紙副本（如適用）
Personal Accident Benefits 人身意外保障	
Accidental Death 意外死亡 Permanent Disablement 永久傷殘	✓ Copy of full medical report 詳細醫療報告副本 ✓ Copy of Police Statement for the accident 所有警方口供紙副本 ✓ Original Letter of Authorization signed by Policy Holder 保單持有人簽署的授權書正本 ✓ Copy of Death certificate and/or autopsy report (if applicable) 死亡證及 / 或驗屍報告副本（如適用） ✓ Grant of Probate / Letters of Administration (if applicable) 授予遺囑認證書 / 遺產管理書（如適用） ✓ Permanent Disablement Benefit section completed by Registered Medical Practitioner (if applicable) 由註冊醫生完成填寫的永久傷殘部分（如適用） ✓ Original Letter of Authorization signed by Insured Person for medical record (if applicable) 受保人簽署的授權書正本以索取醫療紀錄（如適用）

Personal Liability 個人責任	
Personal Liability 個人責任	✦ **Please do not make any promise or pay for any claim against you nor admit liability thereof without our consent; All writs, summons, letters or communications regarding any such claim must be sent to us immediately unanswered.** **受保人切勿未經本公司同意，對第三者作出任何法律責任承諾，或同意任何賠償；任何令狀、傳票、書信或通訊皆不須作出回覆，應立即郵寄到本公司作進一步處理。** ✓ Demand correspondences of claim from third party 第三者索償文件 ✓ Photo(s) to show the accident scene, damaged item and/or extend of injury of third party 意外環境及第三者損毀物品及 / 或損傷的相片 ✓ Report or statement from police or relevant authorities (if applicable) 由警方或相關機構發出的報告或口供（如適用） ✓ Original Letter of Authorization signed by Insured Person / Policy Holder 受保人/保單持有人簽署的授權書正本
Others 其他	
Repatriation 送返回國 Replacement 補聘家傭 Service Interruption 服務中斷 Family Member Medical Expenses 家庭成員醫療費用	✓ Original receipts of relative expenses 相關費用收據正本 ✓ Copy of full medical report 詳細醫療報告副本 ✓ Copy of Police Statement for the accident (if applicable) 所有警方口供紙副本（如適用） ✓ Benefit related to hospitalization section completed by Registered Medical Practitioner 由註冊醫生完成填寫的住院相關部分 ✓ Copy of employment contract with temporary domestic helper 臨時家傭的僱傭合約副本
Fidelity Protection 忠誠保障	✓ Original receipts of relative expenses 相關費用收據正本 ✓ Copy of Police Statement for the accident 所有警方口供紙副本 ✓ Copy of the proof of your pecuniary loss 金錢損失證明副本 ✓ Original Letter of Authorization signed by Insured Person / Policy Holder 受保人/保單持有人簽署的授權書正本

This section is to be completed by the attending Registered Medical Practitioner at the claimant's own expense.
此部分須由主診註冊醫生填寫，所需費用由索償人自行承擔。
Please fill in this section when claiming for Permanent Disablement Benefit
如索償永久傷殘保障，請填妥下表

Patient Basic Information 病人基本資料

Name of Patient: 病人姓名：	HKID No. of Patient: 病人香港身份證號碼：	Date of Injury: 受傷日期：

Attending Registered Medical Practitioner's Statement 主診註冊醫生證明書

Diagnosis (in respect of the disability described in accident details) 診斷（有關索償申請表描述之殘疾）

Had the patient become permanently, totally and irrecoverably disabled? ☐ Yes 是 ☐ No 否
病人是否永久、完全及不可復原的傷殘？

If yes, please provide the details 如「是」，請提供詳情：

Part of disabled 傷殘部位：

☐ Hand 手 ☐ Leg 腳
☐ Head 頭 ☐ Eye 眼
☐ Others 其他：

Severity of disability / injury 傷殘 / 受傷程度：

First consultation date (DD/MM/YYYY): 首次求診日期 (日 / 月 / 年)：	Name of referring Registered Medical Practitioner (if any): 轉介註冊醫生姓名（如有）：

Has the patient ever had the same or similar symptoms / medical conditions before? ☐ Yes 是 ☐ No 否
病人是否曾經患有同一或相似病徵？

If yes, please provide the details 如「是」，請提供詳情：

Declaration 聲明

I hereby certify that all information given above is accurate and true to the best of my knowledge.
本人特此聲明，就本人所知，上述所有資料均準確無誤。

Contact Telephone Number 聯絡電話號碼	Email Address 電郵地址	Address 地址
Signature of the Registered Medical Practitioner with official chop 註冊醫生簽署及蓋章	Name of Registered Medical Practitioner 註冊醫生姓名	Signature Date 簽署日期

This section is to be completed by the attending Registered Medical Practitioner at the claimant's own expense.
此部分須由主診註冊醫生填寫，所需費用由索償人自行承擔。
Please fill in this section when claiming items related to hospitalization
如索償之保障與住院相關，請填妥下表

Patient Basic Information 病人基本資料

Name of Patient
病人姓名 ____________________

HKID Number
香港身份證號碼 ____________________

Name of Hospital / Clinic admitted
入住醫院 / 診所名稱 ____________________

Hospitalization Period (DD/MM/YYYY, hh:mm)
入院日期 (日 / 月 / 年，時 : 分)
From 由 ____________________ To 到 ____________________

Level of ward class 入住病房級別

☐ Day Centre / Clinic 日間中心 / 診所
☐ Semi-private 半私家房
☐ Ward 普通病房
☐ Private 私家房

Consultation Details 診症詳情

1. Clinical History 門診病歷

Symptom(s) or diagnosis(s) 病徵 / 診斷結果

First consultation date 首次求診日期 (DD/MM/YYYY 日 / 月 / 年)	How long had the patient been experiencing these symptoms before the first consultation? 病人在首次求診前已患有此症多久？

2. Hospitalization Details 住院詳情

Final diagnosis 最後診斷	Date of operation 手術日期 (DD/MM/YYYY 日 / 月 / 年)

Operation procedure(s) performed 手術詳情

If the patient has been referred to other Registered Medical Practitioner during this hospitalization, please provide the following
如病人於是次住院期間曾被轉介向其他註冊醫生求診，請提供以下資料

Name of Registered Medical Practitioner consulted
求診註冊醫生姓名 ____________________

Reason(s) and treatment(s) performed by Registered Medical Practitioner
求診原因及治療詳情 ____________________

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Please give a brief discharge summary (including onset and duration of sign and symptoms / disease, etiology, types and results of major examinations, treatments, complications and follow up plan) 請提供出院摘要（包括病發及疾病徵狀、病因、類型及主要檢查、治療、併發症之結果及跟進計劃）	Please provide reason(s) of hospitalization if this type of cases can be managed on day care / out-patient basis 如這類個案可於日間護理 / 門診護理處理，請提供入住醫院原因

3. Professional Comment 專業意見

Is this a chronic/recurrent illness? 此情況是慢性 / 復發性疾病？ ☐ Yes 是 ☐ No 否

To the best of your knowledge, has the patient ever had the same or similar symptoms/medical conditions before? If yes, please state the date of consultation, details of conditions and diagnosis 據閣下所知，病人是否曾經患有同一或相似病徵？如有，請提供詳情 ☐ Yes 是 ☐ No 否

Was the condition due to / associated with the following? (Please tick the appropriate boxes)
上述情況是否由於或與以下問題相關？（請選擇適當空格）

☐ Accidental bodily injury 意外身體受傷
☐ Pregnancy 懷孕
☐ Congenital condition 先天性疾病/異常
☐ Developmental condition 發展障礙
☐ Self-inflicted injury 自我傷害
☐ Infertility or sterilisation 不育或絕育
☐ Contraception 避孕
☐ Hereditary condition 遺傳性問題
☐ Abuse of drugs or alcohol 濫用藥物或酒精
☐ Mental disorder 精神紊亂
☐ General check-up 一般身體檢查
☐ Refractive error 視力問題
☐ Treatment for cosmetic purpose 美容手術
☐ Vaccination 疫苗接種
☐ N/A 不適用
☐ Venereal disease, sexually transmitted disease or AIDS / HIV related illness 性病、性傳染病或愛滋病 / 與愛滋病毒有關的疾病

4. Others 其他

a. If the patient was referred by other Registered Medical Practitioner, please provide the referring Registered Medical Practitioner's name and address
如病人為其他醫生轉介，請提供該轉介醫生之姓名及地址

b. Are you the patient's usual Registered Medical Practitioner? ☐ Yes 是 ☐ No 否
閣下是否該病人的慣常註冊醫生？

Declaration 聲明

I hereby certify that all information given above is accurate and true to the best of my knowledge.
本人特此聲明，就本人所知，上述所有資料均準確無誤。

Contact Telephone Number 聯絡電話號碼	Email Address 電郵地址	Address 地址
Signature of the Registered Medical Practitioner with official chop 註冊醫生簽署及蓋章	Name of Registered Medical Practitioner 註冊醫生姓名	Signature Date 簽署日期