

**Please fill out legibly with Block letters**

**Medical Confirmation**

SB / RA

**Patient:** Name: \_\_\_\_\_  
Date of birth: \_\_\_\_\_  
Place of birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
SSN: \_\_\_\_\_

I have been treating the above-named patient since \_\_\_\_\_ (date).

I am personally acquainted with him/her and he/she has proved his/her identity by presenting to me the following official proof of identification bearing a photograph:

\_\_\_\_\_ (nature of identification) \_\_\_\_\_ (identification no.)

I last treated him/her personally on \_\_\_\_\_ (date) and, for the purpose of presenting this confirmation to the German compensation authorities, I do hereby confirm that he/she was alive on this date and that, to my knowledge, he/she is still alive today.

**Please Note:** The date of the last treatment indicated in the medical confirmation must not date back more than two months.

Furthermore, I also hereby confirm that, as a result of the following illnesses (precise details on illnesses):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

he/she is  bedridden and/or not transportable

not capable of signing himself/herself  
(Please cross where appropriate)

**Please Note:**

The compensation authorities trust in the accuracy of your confirmation and will continue to grant current pension payments on the basis thereof! We thus request that you pay special attention to determining the accuracy of the above details and that you demand the presentation of an identification document bearing a photograph in any event in order to ascertain true identity!

**Warning:** False confirmations are punishable and will give rise to prosecution.

**Confirming physician:**

**Gesehen-Vermerk  
der deutschen Auslandsvertretung**

name, first name:	
address:	
licence number:	
date/ doctor's signature	

Dienstsiegel und Unterschrift
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