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Member Number
(if unknown, leave blank)

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Emergency Travel Plan (ETP) Physician's Statement

I hereby authorize any hospital, physician, or other person who has attended my family member to disclose when requested to do so by the Government Employees' Benefit Association, Inc. (GEBA), or its representatives, any and all information with respect to any illness, injury, or medical history, consultation, prescriptions, or treatment, and copies of all hospital or medical records (if necessary).

Claimant's Name:

Signature: _____

Date:

Attending Physician's Statement:

Patient's Name:

Age:

Nature of Illness/Injury:

Was this a preexisting condition? ☐ Yes ☐ No

Date the symptoms first appeared or accident occurred:

Date of your first treatment of the patient:

Was the patient treated by anyone else? ☐ Yes ☐ No

If so, by whom?

When?

Please specify the date (approximate) of the patient's most recent decline in health:

In your opinion was this recent decline in health serious enough to require the attendance of the claimant named above? ☐ Yes ☐ No

If yes, please
explain:

Attending Physician's Name:

Physician's Signature: _____

Date:

Physician's Address:

Physician's Phone Number: