PHYSICIAN'S STATEMENT OF DISABILITY

(PLEASE PRINT)
Please complete all relevant sections as thoroughly as possible and include medical documentation to support your findings.

THIS SECTION IS TO BE COMPLETED BY THE PATIENT

NAME			EMPLOYER NAME
ADDRESS			SOCIAL SECURITY NUMBER
CITY	STATE	ZIP CODE	GROUP POLICY NUMBER
TELEPHONE	OCCUPATION		DATE OF BIRTH

THE REMAINING SECTIONS OF THIS FORM ARE TO BE COMPLETED BY YOUR PHYSICIAN(S)

1. DIAGNOSIS (Including any complications)

(a) Diagnosis (Include ICD-9 or DSM IV-TR Code)

(b) Subjective symptoms

(c) Objective findings (Please attach copies of current X-rays, EKG's, Laboratory Data and any clinical findings as applicable.)

(d) Are symptoms consistent with the clinical findings? ☐ Yes ☐ No, explain

(e) Is illness work related? ☐ Yes ☐ No

(f) If pregnancy please indicate: LMP: _____ EDC: _____ Actual Delivery: _____

2. DATES OF TREATMENT

(a) Date patient first visited you for this accident/illness: *Month Day Year*

(b) Date patient first unable to work due to this accident/illness: *Month Day Year*

(c) List frequency & date(s) patient was examined for this accident/illness:

(d) Date of last visit: *Month Day Year*

3. NATURE OF TREATMENT (Including Surgery & Medications prescribed, if any)

(a) Hospitalization on: *Month Day Year* **THROUGH** *Month Day Year*

(b) Surgery on: *Month Day Year* Type of Surgery:

(c) Name and Address of Hospital

(d) **Medications**	**Type**	**Dosage**

4. PHYSICAL LIMITATIONS / IF APPLICABLE: In an 8-hour work day is your patient able to:

	0 hours	up to 2.5 hours	up to 5.5 hours	greater than 5.5 hours
Climb	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Stoop	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Reach	☐	☐	☐	☐
Walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐

Cardiac - If applicable (American Heart Association)

- ☐ Class 1 - No Limitation
- ☐ Class 2 - Slight Limitation
- ☐ Class 3 - Marked Limitation
- ☐ Class 4 - Complete Limitation

Blood Pressure (last visit) _____

Please indicate the maximum level of ability (sedentary, light, medium, heavy) of your patient to:

_____ Lift _____ Carry _____ Push _____ Pull

Sedentary = 10 lbs. maximum, walking occasionally. **Light** = 20 lbs. maximum, 10 lbs. frequently
Medium = 50 lbs. maximum, 25 lbs. frequently, up to 10 lbs. constantly. **Heavy** - 100 lbs. maximum, 50 lbs. frequently, 20 lbs. constantly.

5. MENTAL IMPAIRMENT / IF APPLICABLE - Please complete the following (incomplete information will delay claim processing):

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Current GAF: _____ Highest GAF in past year: _____ Baseline: _____

Additional Comments:

6. RETURN TO WORK STATUS	**Patient's Regular Occupation**	**Any Other Occupation**
When was patient able to go to work?	☐ Full-time ☐ Part-time _____ / _____ / _____ (Mo. / Day / Yr.)	☐ Full-time ☐ Part-time _____ / _____ / _____ (Mo. / Day / Yr.)

7. REMARKS

Physician Name *(Please Print)*:	Degree & Specialty:
Address: *(Street, City, State, Zip Code)*	
Telephone Number:	Federal Tax ID #:
Physician Signature:	Date: