## STATEMENT OF DISABILITY

**Case Name:**____________________ **Worker #:**________ **Date Issued:**__________

### RELEASE OF INFORMATION

I, ________________________________, hereby authorize the release of all medical information
(Name of Applicant/Recipient)
requested by this form to:

Applicant's/Recipient's Signature: ________________________ Date: ____________

1. **DIAGNOSIS**

| Primary Diagnosis & Code | Secondary Diagnosis & Code | Other |
|---|---|---|
| | | |
| Date of injury or onset of illness | Date of injury or onset of illness | Date of injury or onset of illness |
| | | |

2. **EMPLOYABILITY:** Based on the above diagnosis, this person is:

☐ *Permanently disabled* - can not work at any type of work again or is prevented from engaging in substantial gainful activity for at least one year (SSA defines gainful activity as earnings of more than $800 per month). The diagnosis is consistent with a potential claim for SSI.

☐ *Temporarily disabled*
☐ unable to work for 30 days
☐ unable to work for 60 days
☐ unable to work for longer than 60 days; date expected to be able to return to work:______________

☐ ***Able to work with restrictions (describe):*** ____________________________

3. **TREATMENT PLAN/CONDITIONS:**

4. **COMMENTS:**

| Signature of Physician or Medical Authority | Telephone Number | Date |
|---|---|---|
| Printed Name | Address | |

WEL1185 (Rev. 6/04)