DISABILITY STATEMENT

A. GENERAL INFORMATION	
COMPANY NAME:	**GROUP NUMBER:**
EMPLOYEE NAME:	**SOCIAL SECURITY NUMBER:**
EMPLOYEE ADDRESS:	**PHONE NUMBER:**
PATIENT NAME:	**DATE OF BIRTH:**

B. TO BE COMPLETED BY PHYSICIAN		
PATIENTS NAME:		
DATE OF BIRTH:	**HEIGHT:**	**WEIGHT:**

PRIMARY DIAGNOSIS:

Has the patient been continuously disabled (unable to work)?
_____Yes _____No

If disabled, will patient ever be able to return to work?
_____Yes _____No

Are there secondary conditions contributing to the disability?
_____Yes _____No If yes, what are they?

Date of the patients last visit?	**How often do you see the patient?**

Has the patient undergone surgery?
_____Yes _____No If yes, give date, procedure and result.

If no, do you expect surgery to be performed in the future?
_____Yes _____No If yes, give date and type of surgery.

What medication is the patient currently taking?

Please indicate other types and frequencies of treatment.

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Has the patient been referred to a medical rehabilitation or therapy program? **_____Yes _____No If yes, give details.**	
Have you referred the patient for other types of consultations? **_____Yes _____No If yes, give details.**	
Has the patient been hospital confined? **_____Yes _____No If yes, complete the following:**	
Name and address of Hospital	**Dates of Confinement**
What is your prognosis for recovery?	
Has patient achieved maximum medical improvement?	
Give details concerning expected improvement or deterioration:	
Your Name and Address	**Telephone Number** **Fax Number**

Signature of attending Physician **Date**