ATTENDING PHYSICIAN'S STATEMENT

Name of Patient: _____ Date of Birth: _____

Employer Name: _____ (must be completed)

1. HISTORY

(a) Date symptoms first appeared or accident happened? _____/_____/_____
(b) Date patient ceased work because of disability? _____/_____/_____
(c) Has patient ever had same or similar condition? Yes ☐ No ☐
If "Yes" state when and describe:

_____

2. DIAGNOSIS (including any complications)

_____

(a) Date of examination _____/_____/_____
(b) Subjective symptoms: _____
(c) Objective findings (including current x-rays, EKG's, Laboratory Data and any clinical findings):

_____

3. DATES OF TREATMENT

First visit _____/_____/_____
Last visit _____/_____/_____
Next visit _____/_____/_____

4. NATURE OF TREATMENT (including surgery and medications prescribed, if any

_____

_____

(a) Was the patient advised to stop working due to this condition at any time? Yes ☐ No ☐
(b) If yes, dates from: _____/_____/_____ to: _____/_____/_____

If Birth of a Child: C-Section Vaginal Circle One

5. PROGRESS

(a) Has patient Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed? ☐
(b) Is patient Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined? ☐
(c) Has patient been hospital confined? Yes ☐ No ☐ If yes, give Name and Address of Hospital:

_____
_____

Confined from _____ through _____

6. PROGNOSIS ***(This classification is for the purpose of ability to work at current job)***

(a) Is patient now totally disabled? Yes ☐ No ☐
(b) Is patient partially disabled? Yes ☐ No ☐ Must complete (f) if checked yes.
(c) Have you advised the patient to return to work? Yes ☐ No ☐

Questions continued on next page

(d) If yes, please provide return to work date: _____/_____/_____
(e) Full Time ☐ Part Time ☐ If Part Time, number of hours per day _____
(f) What restrictions have you placed on your patient?

_____
_____
_____

7. ADDITIONAL REMARKS/REFERRALS TO ADDITIONAL PROVIDERS

_____
_____
_____
_____

8. ATTACH VISIT NOTES IF ADDITIONAL INFORMATION APPLICABLE

_____ _____ _____
Name (Attending Physician) Print | Name of Practice | Telephone Number

_____ _____
Physician's Signature | Date

_____ _____
Street Address City or Town | T.I.N

Return completed form to:

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