ATTENDING PHYSICIAN'S STATEMENT

THE FOLLOWING REPORT MUST BE OBTAINED FROM A DULY QUALIFIED PHYSICIAN AT THE CLAIMANT'S EXPENSE.

Patient's Name: ____ Date of Birth: ____/____/____

Diagnosis: ____ Date of Onset: _____/_____/_____

Has patient ever had same or similar symptoms? ____

Dates of **total** disability: From __________________________ to ___________________________

Dates of **partial** disability: From __________________________ to _________________________

Expected date patient will be able to return to work: ____________________________________

(NOTE: "unknown" and "undetermined" are not acceptable responses; if you cannot anticipate a return to work date, the disability period will not continue beyond the date of the next scheduled examination.)

Prognosis: ____

Any restrictions once patient returns to work? If yes, please describe: __________________

____

____

Describe what treatment or other intervention might enable the patient to return to work:

____

____

Describe any conditions that are contributing to the symptoms / injury that caused the disability, or are hampering the normal process of recovery from same: __________________

____

____

Date of last examination: ____________ Date of next scheduled appointment: _____________

Physician's Statement: By signing this statement, I am certifying that the above-named patient is disabled from engaging in the duties of their respective occupation;
(_____________________________) for the period stated.

____
Physician's Name and Address (please print)

____ ____________________________
Signature of Physician Date Signed

____
License Number

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