

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