ATTENDING PHYSICIAN'S STATEMENT

Name of Patient:_____ Date of Birth:_____
Patient's Address:_____ City:_____ State:_____ Zip_____
Employer's Name:_____ Policy #:_____

I hereby authorize release of information requested on this form by the below named physician for the purpose of claim processing.

Signed (Patient):_____

1. History:

(a) When did symptoms first appear or accident happen? Date:____/___/____
(b) Day patient ceased work because of disability? Date:____/___/____

(c) Has patient ever had same or similar condition? ( )Yes ( )No
If yes, state when and describe _____

(d) Is condition due to injury or sickness arising out patient's employment? ( )Yes ( ) No

(e) Is condition due to automobile accident, indicate state in which it occurred:_____
(f) Names and address of other treating physicians
Name:_____ Address:_____
City:_____ State:_____ Zip:_____
Name:_____ Address:_____
City:_____ State:_____ Zip:_____

2. Diagnosis (including any complications):

(a) Date of last examination: Date:____/___/____
(b) Diagnosis (including any complications):_____

(c) If disability is due to pregnancy, what is expected/was delivery date: Date:____/___/____
(d) Please describe any complications that would extend this disability longer than for a normal pregnancy:_____

(e) Subjective symptoms:_____

(f) Objective findings (including current X-rays, EKG's, Laboratory Data and clinical findings):

3. Dates of Treatment:

(a) Date of first visit____/____/____ **(b)** Date of last visit____/____/____
(c) Frequency of visits ( ) Weekly ( ) Monthly ( ) Other

4. Nature of Treatment (including surgery and medications prescribed, if any):

_____

_____

_____

5. Program:

(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 _____

_____

6. Cardiac (if applicable):

(a) Function capacity ( )Class 1 (No Limitations) ( )Class 2 (Slight Limitations)
( ) Class 3 (Marked Limitations) ( ) Class 4 (Complete Limitations)

(b) Blood pressure (last visit) Systolic:_____ Diastolic:_____

7. Physical Impairment (as defined in Federal Dictionary of Occupational Titles)

( ) Class 1 - No limitation of functional capacity; capable of heavy work
( ) Class 2 - Medium manual activity
( ) Class 3 - Slight limitation of functional capacity; capable of light work
( ) Class 4 - Moderate limitation of functional capacity; incapable of minimal (sedentary) activity
( ) Remarks:_____

_____

_____

_____

8. Mental/Nervous Impairment (if applicable):

(a) If applicable, please define "stress" as it applies to this claimant_____

_____

_____

_____

(b) What stress and problems in interpersonal relations has claimant had on job, if any?_____

_____

_____

( ) Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)
( ) Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
( ) Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
( ) Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations.
( ) Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)
( ) Remarks:_____

_____

_____

9. Prognosis:

	Patient's Job	Any Other Job
(a) Is patient now totally disabled?	( )Yes ( )No	( )Yes ( )No
(b) If not now totally disabled, when was patient able to resume work?	( )Full Time ( )Part Time	( )Full Time ( )Part Time

(c) What duties of patient's job is he/she incapable of performing?_____

Do you expect a fundamental or marked change in the future? ( )Yes ( )No ( )Yes ( )No

(1) If yes, when will patient recover sufficiently to perform duties? ( )1-mo. ( )3-6 mo. ( )1-mo. ( )3-6 mo. ( )1-3 mo. ( )Never ( )1-3 mo. ( )Never

(2) If no, please explain._____

10. Rehabilitation:

(a) Is patient a suitable candidate for further rehabilitation services?(i.e. cardiopulmonary program, speech therapy, etc.) ( )Yes ( )No If yes, explain under remarks.

(b) Would job modification enable patient to work with impairment? ( )Yes ( )No

	Patient's Job	Any Other Job
(c) When could trial employment commence?	( )Full Time ( )Part Time	( )Full Time ( )Part Time

(d) Would vocational counseling and/or retraining be recommended? ( )Yes ( )No

Name(Attending Physician)_____
Degree/Specialty:_____
Address:_____
City:_____ State:_____ Zip:_____

Signature:_____ Date:___/__/____ Tax ID:_____