DISABILITY REPORT

I. Name _____ DOB: _____/_____/_____ Sex: _____
Last First MI Mo Day Yr -

LICENSED TREATING PHYSICIAN/EVALUATOR: QUESTIONS MUST BE ANSWERED COMPLETELY and LEGIBLY OR FORM MAY BE RETURNED

II. Describe all significant physical and mental illnesses, accidents, deformities, injuries, illnesses and surgeries related to your patient's disability. Specify date(s) applicable to condition(s) listed and attach copies of all related reports.

_____
_____
_____
_____
_____

III. Current diagnoses (List primary diagnosis first)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

IV. Indicate your treatment plan and duration of treatment:

_____
_____
_____
_____
_____
_____

V. Explain in detail your patient's functional limitation(s) in doing medium and/or light (sedentary) work. Base your decision on medical evidence and not on subjective judgment. Attach copies of all medical evidence to this report.

_____
_____
_____
_____
_____
_____

VI. LICENSED PHYSICIAN'S STATEMENT OF DISABILITY

Your patient's disability is expected to be:

[ ] **PERMANENT**

[ ] **AT LEAST 12 MONTHS, RE-EVALUATION NEEDED**: _____
(MO/YR)

[ ] **TEMPORARY TO**: _____
(MO/YR)

_____ _____
(Print/Type Name of Licensed Treating Physician/Evaluator) (Signature of Licensed Treating Physician/Evaluator)

_____ _____
(Address) (City) (Zip Code) (Phone No.) (Date)

_____ _____
(Name of Health Plan) (Medical Provider No. or NPI)

VII. PATIENT ACKNOWLEDGEMENT

_____ _____
(Print/Type Name of Applicant/Beneficiary) (App./Ben. or Auth. Rep. Contact Number)

_____ _____
(Signature of App./Ben. or Authorized Representative) (Date)

If Applicant/Beneficiary or Authorized Representative does not sign, please indicate reason below:
_____
_____

FOR OFFICIAL USE ONLY

_____ _____
(Case Name) (Case No.)

_____ _____
(Worker's Name) (Section Unit)

_____ _____
(Unit Address) (Phone No.) (Fax No.)