## SECTION B: TO BE COMPLETED BY PHYSICIAN

note to physician:

Completion of this form will assist your patient in presenting claim for group and/or individual disability benefits. please complete all areas of the form; if a section is non-applicable, please enter n/a in the response area.

| 1a Patient's last name | 1b Patient's first name | 1c M.I. | 2 Birthdate (mm/dd/yyyy) |
|---|---|---|---|
| | | | |

| 3 Current diagnosis | 4 ICD-9 code/DSM IV |
|---|---|
| 5 Subjective findings | 6 Objective findings |
| 7 Has patient ever had same or similar condition? ☐ Yes ☐ No<br>If yes, please specify dates of treatment: | 8 Did injury or illness arise out of or in course of employment ?<br>☐ Yes ☐ No ☐ Unknown If yes, please explain: |
| | |
| 9 Was patient hospitalized? ☐ Yes ☐ No<br>If yes, please provide dates of confinement and name of hospital/facility: | 10 Nature of surgical procedure, if any. (Describe in full.)<br>Date performed (mm/dd/yyyy): ____________ |

## TREATMENT

| 11 Date patient first unable to perform job duties (mm/dd/yyyy) | 11 Date of first visit (mm/dd/yyyy) | 12 Date of last visit (mm/dd/yyyy) |
|---|---|---|
| | | |

| 13 Patient's present condition | 14 Frequency of visits |
|---|---|
| ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed | ☐ Weekly ☐ Monthly Other: ____________ |

15 Treatment plan

16 Functional impairments

## EXTENT OF DISABILITY

17 Patient released to return to work? ☐ Yes ☐ No

If yes: ☐ Full-time, no restrictions Date return to full duty:

☐ Light duty (Please specify restrictions, limitations, hours, graduated return to work schedule, etc.):

Date return to light duty (mm/dd/yyyy): ____________

If no: Estimated date to return to work: (mm/dd/yyyy):____________

## PHYSICIAN INFORMATION

| 18a Physician printed last name | 18b Physician first name | 18c M.I. | 19 Physician specialty |
|---|---|---|---|
| | | | |

| 20a Physician street address | 20b City | 20c State | 20d ZIP code |
|---|---|---|---|
| | | | |

| 21 Physician phone no. | 22 Physician fax no. | 23 Physician e-mail address |
|---|---|---|
| | | |

| Signature of physician | Date (mm/dd/yyyy) |
|---|---|
| X | |

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