ATTENDING PHYSICIAN'S STATEMENT

Patient's Name						Date of Birth
Patient's Address						
Date of first visit Month	Day	Year	Date of last attendance	Month	Day	Year

Were you actively supervising this patient's care during the full period?

☐ YES ☐ NO If NO, please comment in remarks section below.

Frequency of Visits

☐ WEEKLY ☐ MONTHLY ☐ OTHER (SPECIFY) ____

Diagnosis of present disabling condition:	Additional conditions which might affect the duration of disability:

If condition is due to pregnancy, what is (or was) the expected delivery date? Month	Day	Year	Is the patient's condition as a result of a work injury? ☐ YES ☐ NO

Date hospitalized Month	Day	Year	Hospital Name and Address

If surgery performed, please describe:

Date

If patient was referred to you, please give name of referring physician.

To the best of my knowledge, the patient has been **Totally Disabled** (unable to work)

From: Month __________ Day__________ Year_________ To: Month __________ Day__________ Year_________

If still disabled, give **approximate date** patient should be able to return to work

Month __________ Day__________ Year_________

How long will patient be **Partially Disabled**?

From: Month __________ Day__________ Year_________ To: Month __________ Day__________ Year_________

To the best of my knowledge, symptoms first appeared or accident happened:

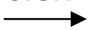
Month __________ Day__________ Year_________

Patient has had same or similar condition ☐ YES ☐ NO	If YES, state when and describe

Remarks:

Physician's Name	Specialty
Physician's Address	Telephone Number

SIGN



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______________________ Physician's Signature ________ Date ______________________ Patient's Signature ________ Date

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