

## ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS AND CONCURRENT CONDITIONS

2. DATES OF HOSPITAL CONFINEMENT, IF ANY

3. DOES CONDITION ARISE OUT OF EMPLOYMENT:

YES       NO

4a. DOES CONDITION ARISE OUT OF PREGNANCY?

YES       NO

4b. IF 'YES', ESTIMATE THE DATE OF DELIVERY:

5. INDICATE NATURE OF SURGERY PERFORMED, IF ANY, INCLUDING OBSTETRICAL PROCEDURE:

6. IS THE PATIENT TOTALLY DISABLED AND UNABLE TO PERFORM ANY KIND OF WORK?     YES     NO

IF NO, CAN PATIENT RETURN TO WORK WITH RESTRICTIONS:     YES     NO

IF YES, PLEASE LIST THE DATES THE PATIENT HAS BEEN TOTALLY DISABLED FROM:    \_\_\_\_\_ THROUGH \_\_\_\_\_

PLEASE STATE RESTRICTIONS (IF APPLICABLE)

6b. EXPECTED DATE OF RETURN TO WORK:

7. OBJECTIVE EVIDENCE OF DISABILITY (LAB/X-RAY, SONOGRAM, FINDINGS, ETC.):

8. INDICATE CLINICAL MANIFESTATIONS OF CONDITION:

9. LIST ALL MEDICATIONS OF CONDITION:

10. PATIENT PROGNOSIS/DATE OF FOLLOW UP APPOINTMENT

11. DATE SYMPTOMS FIRST APPEARED:

12. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION:

13. DATES OF CURRENT SERVICES:

14. DATE

PHYSICIAN'S NAME

SIGNATURE

DEGREE

TELEPHONE

15. STREET ADDRESS

CITY

STATE

ZIP CODE