

ATTENDING PHYSICIAN'S STATEMENT
*THE PATIENT IS RESPONSIBLE FOR THE COMPLETION
OF THIS FORM WITHOUT EXPENSE TO THE COMPANY.*
USE SECOND PAGE OF THIS FORM FOR ADDITIONAL COMMENTS

Name of patient _____ Date of birth _____
Mo./Day/Year
Employer Name _____ Group/Policy No. _____

1. HISTORY

- (a) When did symptoms first appear or accident happen? Mo. _____ Day _____ Year _____
(b) Date patient ceased work because of disability Mo. _____ Day _____ Year _____
(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 of patient's employment? Yes No Unknown
(e) Names and addresses of other treating physicians _____

2. DIAGNOSIS (including any complications)

- (a) Date of last examination Mo. _____ Day _____ Year _____
(b) Diagnosis (including any complications)
(c) Subjective symptoms
(d) Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings)

3. DATES OF TREATMENT

- (a) Date of first visit Mo. _____ Day _____ Year _____
(b) Date of last visit Mo. _____ Day _____ Year _____
(c) Frequency Weekly Monthly Other (specify) _____

4. NATURE OF TREATMENT (Including Surgery and medications prescribed, if any)

5. PROGRESS

- (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 _____
_____ Confined from _____ through _____

6. CARDIAC (If applicable)

- (a) Functional capacity (American Heart Assoc.) Class 1 (No limitation) Class 2 (Slight limitation)
 Class 3 (Marked limitation) Class 4 (Complete limitation)
(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* No restrictions (0-10%)
 Class 2 – Medium manual activity* (15-30%)
 Class 3 – Slight limitation of functional capacity; capable of light work* (35-55%)
 Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%)
 Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75-100%)
 Remarks:

8. MENTAL/NERVOUS IMPAIRMENT (If Applicable)

(a) Please define "stress" as it applies to this claimant.

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

- 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:

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? Yes No

9. PROGNOSIS

- | | | |
|---|--|--|
| | PATIENT'S JOB | ANY OTHER WORK |
| (a) Is patient now totally disabled? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (b) 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 mos.
Mo. Day Year 1-3 mos.

_____ 1 mo. 3-6 mos.
 Never Mo. Day Yr. 1-3 mos. 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
- (b) Can present job be modified to allow for handling with impairment? Yes No

- | | | |
|---|--|--|
| | PATIENT'S JOB | ANY OTHER WORK |
| (c) When could trial employment commence? | <input type="checkbox"/> Full-Time
<input type="checkbox"/> Part-Time | <input type="checkbox"/> Full-Time
<input type="checkbox"/> Part-Time |

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

11. REMARKS

Name (Attending Physician) Print	Degree	Telephone
Street Address	City or Town	State or Province
Signature		Date