Attending Physician's Statement

The patient is responsible for completion of this form without any expense to the company.
Return completed form to employer.

Patient's Name		Patient's Birth date (MM/DD/YYYY)
Date of Illness (first symptom) or injury (accident or pregnancy (LMP)	Date first seen and treated by you for this condition	If patient has had similar illness or injury, give dates
Date patient able to return to work (MM/DD/YYYY). If unknown, give estimate	DATE OF TOTAL DISABILITY MM DD YY MM DD YY from / / through / /	DATE OF PARTIAL DISABILITY MM DD YY MM DD YY from / / through / /
Name of referring physician	For services related to hospitalization give hospitalization dates Admitted / / Discharged / /	

Diagnosis or nature of illness or injury (please indicate primary and secondary)

1.

2.

3.

DATES OF TREATMENT MM DD YY	Regimen of treatment to be prescribed (including number of visits, general nature and duration of treatment, including referral to other provider of health services)
/ /	
/ /	
/ /	
/ /	

LIMITATIONS

(A) What are the patient's present capabilities?

(B) What are the patient's present limitations (physical and/or mental)?

(C) What restrictions are placed on the patient?

PHYSICAL IMPAIRMENT – as defined in Federal Dictionary of Occupational Titles

	Class 1 – No limitations of functional capacity; capable of heavy work. No restrictions. (0 – 10%)
	Class 2 – Medium manual activity. (13 – 30 %)
	Class 3 – Slight limitation of functional capacity; capable of light work. (35 – 50%)
	Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60 – 70%)
	Class 5 – Severe limitations of functional capacity; incapable of minimal (sedentary) activity. (75 – 100%)

Physician's Name & Address	Telephone Number ( ) Fax Number ( )
Physician's Signature	Date (MM/DD/YYYY