Attending Physician's Statement

Complete this form in full.

- The patient is responsible for completion of this form without expense to the company.
- You may use the Remarks section on the reverse side if you need more room to respond.

Patient Information

Name | Social Security Number | Birthdate (MM/DD/YYYY)

Address (include No. Street, Town, State, Zip Code) ☐ Address is new

Employer Information

Name

1. History

(a) Height ____________ Weight ____________

(b) Date symptoms first appeared or accident happened .... Mo. ______ Day ______ Yr. ______

(c) Date patient ceased work because of disability .... Mo. ______ Day ______ Yr. ______

(d) Has patient ever had same or similar condition? ☐ No ☐ Yes, state when and describe.

(e) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown

(f) Names and addresses of other treating physicians

Name ____________ Address ____________

Name ____________ Address ____________

Name ____________ Address ____________

2. Diagnosis

(a) Date of last examination .... Mo. ______ Day ______ Yr. ______

(b) ICD diagnostic code (**mandatory**)

(c) Diagnosis (including any complications) ____________

(d) Subjective symptoms

(e) Objective findings (including **current** X-rays, EKG's, laboratory data and any **clinical findings**):

(1.) **Clinical Findings**:

(2.) **Diagnostic Studies and Results**:

(f) If disability is due to pregnancy, the expected delivery date is .... Mo. ______ Day ______ Yr. ______

(g) Other disease or infirmity affecting present condition ____________

3. Dates of Treatment

(a) Date of first visit .... Mo. ______ Day ______ Yr. ______

(b) Date of last visit .... Mo. ______ Day ______ Yr. ______

(c) Frequency .... ☐ Weekly ☐ Monthly ☐ Other (specify) ____________

(d) Is patient still under your care for this condition?

☐ Yes ☐ No, indicate date service terminated. ____________

4. Nature of Treatment

(a) Type and dates of treatment:

(b) Prescribed medications:

(c) Surgical procedures and dates:

5. Progress

(a) Patient has .... ☐ Recovered ☐ Improved ☐ Stabilized ☐ Retrogressed

(b) Patient is .... ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

(c) Has patient been hospital confined?

☐ No ☐ Yes, give name and address of hospital ____________

____

Confined from ____________ through ____________

6. Cardiac (if applicable)

(a) Functional capacity limitation (American Heart Ass'n): ☐ Class 1 (none) ☐ Class 2 (slight) ☐ Class 3 (marked) ☐ Class 4 (complete)

(b) Blood Pressure (last visit): ____________ / ___________
Systolic / Diastolic

7. Limitations

(a) What are patient's present capabilities?

____

(b) What are present limitations (physical and/or mental)?

____

(c) What restrictions are placed on patient?

____

8. 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: ____

____

9. Mental/ Nervous Impairment (if applicable)

Please define "stress" as it applies to this claimant.

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

10. Prognosis

(a) What is the patient's prognosis?
☐ Guarded ☐ Good ☐ Fair ☐ Poor ☐ Other

(b) When do you feel patient's maximum medical improvement will be reached?
☐ 1 Mo. ☐ 1-3 Mos. ☐ 3-6 Mos. ☐ 6-9 Mos. ☐ 1 yr. or longer

(c) What is the estimated date of the patient's return to work?
☐ own job/occ ☐ other occ ☐ no return expected

(d) Do you consider the patient to be a viable candidate for **Vocational Rehabilitation** (job retraining)?
☐ Yes ☐ No, please explain ____

____

Remarks

Attending Physician's Name (print)	Specialty	Degree

Address (No. Street, City, State, Zip Code)	Telephone

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant. California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

Signature	Date