Physician Statement for Disability Insurance

Patient Name		
Date of Birth		
Policy/Claim Number		
Diagnosis		
Date Symptoms First Appe	ared	
Date Patient First Consulted	d You for This Condition	
Nature of Disability		
Current Treatment Plan		
ls the Patient Able to Perfor	m Occupational Duties?	
Estimated Duration of Disal	bility	
Additional Comments		
Physician Name		
Physician License Number		

Address	
Phone	
Date	
Signature	