Physicianâ€™s Statement for Disability Claim

Patient Information

Full Name

Date of Birth

Claim/Policy Number

Address

Phone Number

Physician Information

Physician Name

Specialty

Phone

Address

Medical Information

Diagnosis

Date Symptoms First Appeared

Date Patient First Consulted You

Treatment Provided

Is the Condition Due to Injury or Sickness Related to Employment?

Current Functional Limitations

Disability Information

Date Patient Became Disabled

Date Patient is Expected to Return to Work

Expected Duration of Disability

Additional Comments

Physicianâ€™s Certification

Physicianâ€™s Signature

Date