Physician Statement for Disability Insurance

Patient Information

Full Name

Date of Birth

Address

Phone Number

Physician Information

Physician Name

Specialty

Practice Name/Address

Phone

Medical Diagnosis

Primary Diagnosis

Other Relevant Diagnoses

Medical History

Date Symptoms Began

Date of First Visit

Date of Last Visit

Frequency of Visits

Summary of Treatment Provided

Functional Limitations

Describe Patientâ€™s Limitations

Ability to Perform Usual Occupation

Ability to Perform Other Work

Prognosis

Estimated Duration of Impairment

Is Patient Expected to Recover?

Recommended Restrictions

Physician Certification

Physician Signature

Date