

**WORKER'S DISABILITY  
ATTENDING PHYSICIAN'S REPORT**

PATIENT'S NAME \_\_\_\_\_

PATIENT'S ADDRESS \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_ OCCUPATION \_\_\_\_\_

HISTORY OF OCCURANCE AS DESCRIBED BY PATIENT \_\_\_\_\_

DIAGNOSIS AND CONCURRENT CONDITIONS:  
\_\_\_\_\_  
\_\_\_\_\_

WHEN DID SYMPTOMS FIRST APPEAR? (DATE): \_\_\_\_\_

WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? \_\_\_\_\_

HAS PATIENT EVER HAD THE SAME OR SIMILAR CONDITION? YES \_\_\_\_\_ NO \_\_\_\_\_

If "YES" state when and describe: \_\_\_\_\_  
\_\_\_\_\_

WAS CONDITION CAUSED, AGGREVATED OR CONTRIBUTED TO PATIENT BY EMPLOYMENT? Y \_\_\_\_\_ N \_\_\_\_\_

Explain: \_\_\_\_\_  
\_\_\_\_\_

PATIENT WAS DISABLED (unable to work) FROM: \_\_\_\_\_ TO: \_\_\_\_\_

IF STILL DISABLED, PATIENT SHOULD BE ABLE TO RETURN TO WORK ON: \_\_\_\_\_

IF PATIENT WAS HOSPITALIZED, NAME OF HOSPITAL: \_\_\_\_\_

DATE(S) OF HOSPITALIZATION(S): \_\_\_\_\_

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES \_\_\_\_\_ NO \_\_\_\_\_

Attach itemized bill TOTAL AMOUNT: \_\_\_\_\_

DATE \_\_\_\_\_

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
PHONE

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_