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: _____

_____

_____