



ATTENDING PHYSICIAN'S STATEMENT

CLAIM NUMBER: _____
POLICY NUMBER: _____

1. Insured's Name (First) _____ (Last) _____ Date of Birth ____/____/____
 Month Day Year

2. History:

A. When did symptoms first appear/accident happen? ____/____/____
 Month Day Year
 Date patient ceased work due to disability: ____/____/____
 Month Day Year

B. Has patient ever had same or similar conditions? Yes No If Yes, state when and describe

C. Is condition due to injury or sickness arising out of patient's employment? Yes No Unknown

D. Is condition due to pregnancy? Yes No
 If Yes, Estimated Date of Conception: ____/____/____
 Month Day Year

E. Have you treated this individual for any other conditions? Yes No If Yes, state when and describe:

F. Have you completed claim forms for other insurance carriers? Yes No If Yes, state name of
 insurance company: _____

G. Name and address of other treating physicians or consultants (If none, write none): _____

3. Diagnosis:

A. Primary diagnosis _____

B. Secondary diagnosis (include complications): _____

C. Subjective symptoms: _____

D. Objective findings: To assist us, we request your cooperation in forwarding: the results of diagnostic tests
 already taken. For example: electrocardiograms, angiograms, etc., for a heart condition; vital capacity
 readings for emphysema; x rays for musculoskeletal disorders and the results found through the use of other
 clinical techniques. For pregnancy, describe any complications.

4. Dates of treatment (include all dates)

A. Office: Date of first visit: _____ / _____ / _____ Additional dates: _____
Month Day Year

B. Has patient been hospital confined? Yes No
If Yes, confined _____ / _____ / _____ to _____ / _____ / _____
Month Day Year Month Day Year

If Yes, name and address of hospital: _____

5. Nature of treatment (include surgery/medication prescribed/physical therapy, if any): _____

6. Extent of disability: Has patient been released to return to work? Yes No

If Yes, give date: _____ / _____ / _____
Month Day Year

7. If patient has not been released to return to work, answer A through D.

A. In your opinion, is the patient unable to work in his/her occupation? Yes No
If Yes, give dates: _____ / _____ / _____ to _____ / _____ / _____
Month Day Year Month Day Year

B. If still unable to work in his or her occupation, when do you expect patient will be able to perform some of his/her work duties?
 1-3 months 3-6 months 6-12 months more than 12 months

C. If patient is able to do some work, how long until patient is able to perform all of his/her work duties:
From _____ / _____ / _____ to _____ / _____ / _____
Month Day Year Month Day Year

D. What are patient's present limitations? _____

Attending Physician's Name (Please Print)	Degree	Telephone
Street Address	City	State
		ZIP Code
Signature	Date	TIN