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ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

Print, and have your physician sign and mail this form to James H. Sandman, P. C.

Patient's Name:____

Address: ____

Date of Birth: _________________ Social Security #: _______________________

1.	Date of Injury:
2.	Date of 1st Consult:
3.	For the following reasons:
4.	DIAGNOSIS: Is treatment ongoing? Yes ( ) No ( ) If not, date of last treatment? ______________________
5.	DISABILITY: Total Disability from: ___________________ to ___________________ Partial Disability from: ___________________ to ___________________
6.	If patient is totally disabled, is the disability permanent and total? Yes ( ) No ( )
7.	If the patient is partially disabled, what restrictions or limitations would you impose when the patient returns to work?
8.	Was the employee's injury causally related to his/her employment? Yes ( ) No ( )
9.	Is the employee's disability causally related to his/her employment? Yes ( ) No ( )
10.	Did the employee have a pre-existing condition? Yes ( ) No ( )
11.	If the employee had a pre-existing condition, was this incident a major cause of the present disability? Yes ( ) No ( )
12.	Comments:

Date:	Physician's Signature:
	Printed Name:
	Address:
	Medical Specialty: