

Part 3 — ATTENDING PHYSICIAN'S STATEMENT

Patient Name _____

This information is required to initiate Weekly Disability Benefits. Follow-up verification of condition may be requested.

1. Diagnosis (if fracture or dislocation, describe nature and location)

2. Is condition due to injury or sickness arising out of patient's employment? Yes No
If "Yes" explain

3. When did symptoms first appear or accident happen? (If pregnancy, LMP date)

4. When did patient first consult you for this condition?

5. Nature of surgical or obstetrical procedure, if any (describe fully)

5A. Date performed _____

5B. Was patient hospitalized? Yes No Dates

6. List dates of other medical (non-surgical) treatment, if any

7. Was patient referred to you?

Yes No

7A. If referred, name and address of referring physician

7B. Did you refer this patient to another physician? Yes No
If yes, Name of Physician

8. Is patient still under your care for this condition? Yes No
If "No" give date your services terminated

9. Specify beginning and ending dates of total disability
From _____ To _____

10. Specify beginning and ending dates of partial disability
From _____ To _____

DATE SIGNATURE (ATTENDING PHYSICIAN) PRINT PHYSICIAN'S NAME

DEGREE FED. TAX. NO. PHONE

STREET ADDRESS CITY STATE ZIP CODE