

Name of Employee: _____

Social Security Number: _____

Psychological Functions

Check applicable box below

- Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations)
- Class 2 – Patient is able to function in most stress situations and engage in some interpersonal relations (slight limitations)
- Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks:

What stress factors or problems with interpersonal skills have affected patient's ability to perform the duties of his or her job?

Is patient competent to endorse checks and direct use of the proceeds? Yes No

Physical Capabilities

(a) Patient's ability to: (circle)

	Hours	(check)
Sit	0 1 2 3 4 5 6 7 8	<input type="checkbox"/> Continuously <input type="checkbox"/> Intermittently
Stand	0 1 2 3 4 5 6 7 8	<input type="checkbox"/> Continuously <input type="checkbox"/> Intermittently
Walk	0 1 2 3 4 5 6 7 8	<input type="checkbox"/> Continuously <input type="checkbox"/> Intermittently

(b) Patient's ability to: (circle)

Climb	Yes	No
Twist/bend/stoop	Yes	No
Reach above shoulder level	Yes	No
Operate a motor vehicle	Yes	No

(c) Patient's ability to lift/carry: (check)

	Never 0%	Occasionally 1-35%	Frequently 36-66%	Continuously 67%-100%
Up to 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 to 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Over 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(d) Patient's ability to perform repetitively: (circle)

	Right Hand	Left Hand
Fine finger movements	Yes No	Yes No
Eye/hand movements	Yes No	Yes No
Pushing/pulling	Yes No	Yes No
Dominant hand	R _____	L _____

(e) In your opinion, why is patient unable to perform job duties?

(f) Patient can work a total of _____ hours per day?

(g) Do you expect improvement in any area?
(If so please comment and give dates/timeframes.)

Cardiac

Functional Capacity (American Heart Association) Complete only if applicable.

- Class 1 (No Limitation) Class 2 (Slight Limitation) Class 3 (Marked Limitation) Class 4 (Complete Limitation)

Blood pressure (latest reading) _____ / _____ as of (date) _____ / _____

Is patient in a cardiac rehabilitation program?

Prognosis

Have you advised patient to return to work?

- Yes If Yes, date of return _____ To regular occupation Full Time Part Time
- No If not, please explain. To any other occupation Full Time Part Time

Any work/activity restrictions applicable (please be specific):

Rehab

Do you suggest that the patient become involved in any of the following? Please check as many as apply.

If so, was this discussed with the patient? Yes No

- Physical Therapy Pain Management Program Vocational Rehabilitation
- Occupational Therapy Work Hardening Program Psychological Counseling
- Cardiac Rehabilitation Job Modification Other _____



Continued on Following Page

Disability Claim Attending Physician Statement (Continued)

Name of Employee: _____ Social Security Number: _____

Fraud Warning:

If you reside in one of the following states, one of the following state warnings may apply to you:

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. I know that if I do this, I may also have to pay a civil penalty of up to \$5,000 plus the value of the claim.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, files a claim containing a false or deceptive statement may have violated state law.

If you reside in any state other than those listed above, then the following warning may apply to you:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Physician	
Name _____	Degree/Specialty _____
Street Address _____	City _____ State ____ Zip Code _____
Telephone # (____) _____	Fax # (____) _____ Tax ID # _____
Contact person if additional information is necessary _____	
Signature _____	Date _____

