DISABILITY INFORMATION

Date: _____ **Phone No: _____**

Patient's Name: _____ Date of Birth: _____

Employer: _____ Work Related Injury? ☐ Yes ☐ No

Treating Doctor: _____

Form being completed for what condition
Condition _____ Right ☐ Left ☐

Surgery? ☐ Yes ☐ No **Date of Surgery: _____**

Inpatient ☐ Outpatient ☐ **Admit Date: _____ Discharge: _____**

First Date Off Work: _____ Return To Work Date: _____ Unknown ☐

Is disability for intermittent leave? ☐ Yes ☐ No

_____

_____

_____

If you would like form to be faxed #: _____ Attn: _____

OFFICE USE ONLY:

Payment Type
☐ Cash

☐ Check

☐ Credit Card

☐ Business Office Info taken by: _____

Clerk Initial:_____