

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 and 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	Occasionally	Frequently	Continuously
	0%	1-35%	36-66%	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 _____

Disability Claim Attending Physician Statement (Continued)

Name of Employee: _____ Social Security Number: _____

Fraud Warning:

If you are insured under a policy issued in one of the following states, or 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.

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 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.

Kansas, Oregon, Washington and Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

If you are covered under a self-funded plan or insured under a policy issued in any state other than those listed above, or 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 may be a crime and may subject 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 _____