

Disability Forms
Physician's Statement Forms
Medical Leave Forms

Please Read Carefully

Date: _____ Physician: _____

All patient portions of the form must be completed by patient and authorization signed.

The charge for completing each form is \$20.00 and will need to be paid before the form is completed. Forms to be mailed must be prepaid.

Please **allow at least 10 working days for completion**, depending on your medical record availability.

1) Patient Name: _____

2) Injury Date: _____

3) Phone Number: _____

4) Check One:

- Mail to you (Prepaid only)
- Mail to Insurance (Prepaid only)
- Mail to Employer (Prepaid only)
- Pick-up (Prepaid only)
- Fax to Insurance (Prepaid only)

5) Last Day Worked: _____

6) Expected Return to Work Date: _____

7) Type of Injury: _____

8) Did you have surgery: _____

9) Date of surgery/admitted: ___ _____

10) Date of Discharge: _____

Additional Comments: _____

Patient signature: _____