APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS
ATTENDING PHYSICIAN'S STATEMENT

HISTORY

Patient's Name	Social Security Number	Date of Birth
Is condition due to an illness or an injury that is work related	Height	Weight

Patient's condition is the result of: ☐ illness ☐ Injury ☐ Pregnancy ☐ Mental/ Nervous Condition

If pregnancy, what is the expected date of delivery? Month_____ Day_____ Year_____ LMP Date_____

DIAGNOSIS

Diagnosis (including any complications)	ICD9 Codes

TREATMENT

Date of onset of this condition?	List all dates of treatment for this condition since patient ceased work	Date of next office visit

Has patient been referred to any other physician? ☐ Yes ☐ No If "Yes," date(s)_____ _____ _____
Name and address_____ Specialty_____

Nature of treatment for this condition (including surgery/medications)_____

Was patient hospitalized for this condition? ☐ Yes ☐ No If "Yes," date(s) admitted_____ date(s) discharged_____

Name and Address of Hospital(s)_____

Was surgery performed? ☐ Yes ☐ No If "Yes," Date_____ Procedure_____ CPT Code_____

Progress (please check one): ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

IMPAIRMENT

What are the patient's current physical limitations and restrictions?

☐ No limitation of functional capacity; capable of heavy work, no restrictions.
(Lifting 100 lbs. maximum with frequent lifting and/or carrying objects weighing up to 50 lbs.)

☐ Medium manual activity
(Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.)

☐ Slight limitation of functional capacity; capable of light work
(Lifting 20 lbs. maximum with frequent lifting and/or carrying objects weighing up to 10 lbs. This job category involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls and can require walking or standing to a significant degree.)

☐ Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity
(Lifting 10 lbs. maximum and occasionally lifting and/or carrying articles. This sedentary job category is defined as one which involves sitting, and a certain amount of walking and standing is often necessary.)

☐ Severe limitation of functional capacity; incapable of minimal (sedentary) activity

What is the psychiatric impairment (if applicable)?

☐ Inadequate information to make assessment

☐ Essentially good functioning in all areas. Occupationally and socially effective.

☐ Moderate impairment in occupational functioning. Limited in performing some occupational duties.

☐ Major impairment in several areas – work, family relations. Avoidant behavior, neglects family, is unable to work.

☐ Inability to function in almost all areas.

WORK STATUS

How long was or will the patient be totally disabled? From:_____ To:_____
How long will the patient be partially disabled (with physical or psychiatric limitations)? From:_____To:_____

Attending Physician's Name	Social Security Number or E.I.N. Number:	
Address: (Street, City, State & Zip Code)	Telephone Number ( )	Fax Number ( )

Degree_____ Specialty_____

Signature_____ Date Signed_____

FAX, E-MAIL OR MAIL THIS FORM TO: FAX 866-597-2187 SECURE E-MAIL SITE: SECUREMAIL-BSC.COM

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