RE-CERTIFICATION OF DISABILITY

Applicant's Name ____
First Middle Last

Date of Birth ______________

Male _________ Female __________

Diagnosis/Analysis ____

a) Applicant's symptoms ____________________________________
____

b) Objective findings ______________________________________
____

Enter dates for the following:

A) In your opinion, is the applicant disabled at the present time.? YES____ NO____

B) If yes: date disability commenced_______________________

date disability ended or is expected to end_______________________

C) Is disability: total________ partial_______________
Permanent________ temporary__________

D) Date of your first treatment for this disability ___________________
Month Date Year

E) Date of your most recent treatment of this disability _________________
Month Date Year

NOTE: Definition of disabled – impaired, incapacitated, or unable, as a result of illness, disease disorder, other pathological condition or injury, to discharge any normal physical or mental function, whether permanently or temporarily and whether totally or partially, and requiring therapeutic, corrective, rehabilitative or other prescribed treatment or use of prescribed medication or device or devices.

Date of last examination or treatment: _________________________________

I affirm that I am a ____
e.g. Physician, Podiatrist, Chiropractor, Dentist

Licensed in the State of ______________________ License No. ___________________

Doctor's Signature ____

Doctor's Name (Please Print) ______________________________________

Office Address ____
No. Street Town State Zip

Telephone No. ______________________________
Date ______________________________________

6/07