Attending Physicianâ€™s Statement for Disability Coverage

Patient Information

Full Name

Date of Birth

Policy/Certificate Number

Address

Phone Number

Medical Information

Primary Diagnosis

Secondary Diagnosis/Complications

Date Symptoms First Appeared

Date of First Visit for This Condition

Date Patient Ceased Work

Treatment & Medications

Hospitalization (Name, Dates & Address)

Prognosis (Including Estimated Duration of Disability)

Is Condition Work Related?

-- Select --

Is Patient Capable of Performing Any Work?

-- Select --

Physician Information

Name

Specialty

Address

Phone

Physicianâ€™s Signature

Date