Claim No: ______________________

Patient's Name: ______________________

MEDICAL DISABILITY STATEMENT

Specific injury causing disability: ______________________

Causation of injury: ______________________

Patient's occupation: ______________________

Patient's job duties: ______________________

Patient's household responsibilities: ______________________

How is this injury preventing your patient from performing their job duties? __________

____

Please list what activities the patient is **UNABLE** to perform: ______________________

____

Please list the activities the patient is **ABLE** to perform:

Work: ______________________

Home: ______________________

Does your patient have physical restrictions? Yes/No If so, please list them: ________

____

Patient is unable to work from ________ through __________

Patient is able to work part-time duty _________ hours or days per week

Increasing to ____________ hours or days per week _______________

I will re-evaluate the patient on __________________.

Additional comments: ______________________

Physician's name: ________________ ________________ ________________

Printed or typed | Physician's signature | Date

Any person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NCF-PIP109