Attending Physician's Statement of Disability

Name of Patient

1. History

(a) When did symptoms first appear or accident happen? ________________

(b) How long has patient been continuously totally disabled (unable to work)? From __________ through ________

(c) Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, state when and describe ______________

____

(d) Names and addresses of other treating physicians ____

2. Diagnosis

(a) Diagnosis (including any complications) ____

(b) Subjective symptoms ____

(c) Objective findings (including current X-rays, EKG's, laboratory data and any clinical findings) ______________

3. Dates of Treatment

(a) First Visit _______________ (b) Last Visit _________________

(c) Frequency ☐ Weekly ☐ Monthly ☐ Other (specify)

4. Nature of Treatment (including type and date of surgery and medications prescribed, if any)

____

5. Cardiac (if applicable)

Functional capacity (American Heart Ass'n.)

☐ Class 1 (No limitation) ☐ Class 3 (Marked limitation)

☐ Class 2 (Slight limitation) ☐ Class 4 (Complete limitation)

Blood pressure (Last visit)

6. Prognosis

	Patient's job	Any other work
(a) Is patient now totally disabled?	☐ Yes ☐ No	☐ Yes ☐ No
(b) If not now totally disabled, when was patient able to resume work?	☐ Full-time __________ ☐ Part-time __________	☐ Full-time _________ ☐ Part-time _________

(c) What duties of patient's job is he/she incapable of performing? ____

____

(d) Do you expect a fundamental or marked change in the future? ☐ Yes ☐ No

	Patient's job	Any other work
(1) If yes, when do you think patient will recover sufficiently to perform duties? _____/_____/_____	☐ Full-time __________ ☐ Part-time __________	☐ Full-time _________ ☐ Part-time _________

(2) If no, please explain ____

(e) Is patient a suitable candidate for a rehabilitation program? ☐ Yes ☐ No

Remarks

____

____

Name (attending physician)/Please print Degree/Specialty Telephone #

No. Street City St/Prov. Zip/Pac

Signature Date

Please complete and return to: Pro Financial Services, LLC, 500 West Madison Street, Suite 2660, Chicago, Illinois 60661

Please submit copies of all pertinent medical records and any other documents or materials to support submission (i.e. All findings of MRI's, CT Scans, X-rays, diagnostic tests, and operative notes).