PFS
SPECIALTY RISK UNDERWRITERS

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, EKGôs, 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 Assôn.)

□ Class 1 (No limitation)
□ Class 2 (Slight limitation)
□ Class 3 (Marked limitation)
□ Class 4 (Complete limitation)

Blood pressure (Last visit)

6. Prognosis

	Patientôs 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 _____ Full-time _____ □ Part-time _____ Part-time _____	□

(c) What duties of patientôs job is he/she incapable of performing?

_____

_____

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

(1) If yes, when do you think patient will recover sufficiently to perform duties?
_____/_____/_____

Patientôs job	Any other work
□ Full-time _____	□ Full-time_____
□ Part-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 MRIôs, CT Scans, X-rays, diagnostic tests, and operative notes).