Disability Form Instructions:

- **Please Allow 10 to 14 days to Complete**

Is this an update to an existing claim? **YES** or **NO**

PATIENT NAME:_____ DOB:_____
Name: _____ Date: _____
Phone #: _____ Cell #: _____

Occupation and duties:
_____
What duties of your job does your condition prevent you from performing?
_____
_____
_____
Is this a continuous leave: YES NO
Start date of disability (date you stopped/will stop work):_____
Estimated date you plan to return to work: _____
Do you plan on returning to part-time or restricted work (prior to full-time, full release work): **YES** or **NO,** If yes,
Estimated Date:_____, in what capacity?_____

Do you plan on intermittent leave? YES NO
Dates of intermittent leave:_____

What would you like for us to do with your completed form(s)?
Pick Up at Office: YES or **NO** If no:
Mail to, address: _____
_____
Fax to: _____
_____

Official Use Only:
Dr.: _____ Acct#:_____
Type: _____
Rec'd: Date:_____ Initials: _____