

SECTION B- ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Claimant's Name: _____

Please answer all questions

1. Nature of sickness or injury and complications, if any, causing disability? _____

2. What operations, if any, were performed since last statement? _____

3. Give all dates of treatment since last statement: Home _____ Office _____

4. Was claimant hospitalized since last statement? _____ From _____ To _____

Name and Address of Hospital: _____

5. Have any other physicians been in attendance or consultation since last statement? _____

If yes, give their names and addresses: _____

6. Current limitations and restrictions, if any: _____

7. Is this claimant totally disabled from each and every occupation? _____

If no, please explain: _____

8. (a) How long was or will claimant be totally disabled from current occupation? From _____ To _____

(b) How long was or will claimant be partially disabled from current occupation? From _____ To _____

(c) Estimated return to work date: _____

9. What is the prognosis? _____

Doctor's Signature _____ Date _____

Doctor's Name (please print or type) _____ Tel.#() _____

Office Address _____

Number Street City or Town State Zip Code