To Be Completed By Attending Physician
(Please Print or Type)

Patient's Name: _____ Age: _____

Please State:

Patient's Complaints:

Objective Findings (including results of x-rays, laboratory tests, diagnostic studies, B/P, ect., if relevant:

Your Diagnosis:

Brief history of illness or injury

Give all dates of treatments by you during this period of disability:

Home or office:

Hospital:

If the patient was confined as a registered bed patient in a legally constituted hospital during this period of disability, please answer the following:

(a) Name and address of hospital:

(b) Date of admission: _____ Date of discharge: _____

Date of surgery, if any: _____

Surgical Procedure:

Based on your personal knowledge and treatment, how long has the patient been totally disabled by the sickness or injury so that he/she was prevented from working:

From: _____ to and including: _____

In your opinion, is the patient's disability caused by his/her work for Lapeer Schools or any other

Employer:

Yes: _____ No: _____ If yes please explain on a separate sheet

If applicable, is the patient **mentally** capable of transacting his/her personal affairs (for instance, the endorsing of checks) with the realization of he nature and consequences of his/her acts?

Yes: _____ No: _____

Has the patient recovered sufficiently to return to work? Yes: _____ No: _____

If "YES", give the date the patient was able to return to work: _____

If "NO", when, in your opinion may work be resumed? (please do not use the terms indefinite, unknown, undetermined, ect. If a definite date cannot be determined, please approximate in days, weeks, or months, how long total disability will continue from the date of the most recent treatment, as indicated above.)

_____, 19____

Physicians Name (please print or type): _____

Office Address: _____

_____

Specialty Board Certification: