

PHYSICIAN'S STATEMENT
PLEASE ANSWER ALL QUESTIONS-GIVE DATES WHERE CALLED FOR

Patient's Name	Age _____
Nature of sickness or injury. (Describe complications, if any)	
When did symptoms first appear or accident happen?	Date _____, 20__
When did patient first consult you for this condition?	Date _____, 20__
Has patient ever had same or similar condition? (If "yes" state when and describe.)	Yes___ No___
Nature of surgical or obstetrical procedure, if any. (Describe fully.) When and where performed?	Date _____, 20__ If in hospital, inpatient___ outpatient___
Give dates of treatment.	Office _____ Home _____ Hospital _____
Is patient still under your care for this condition? If discharged, give date.	Yes___ No___ Date _____, 20__
If patient is hospitalized, give name and address of hospital.	Hospital _____ City _____ State _____ Zip Code _____ Date Admitted _____, 20__ Date Discharged _____, 20__
How long was or will patient be continuously totally disabled (unable to work)? Note: We do not issue benefits for partial disability.	From _____, 20__ to _____, 20__
Is condition due to injury or sickness arising out of patient's employment? If "yes" explain.	Yes___ No___

Date _____, 20__ _____
(Print attending Physician name)

Sign _____
(Attending Physician)

(Street Address) (City or Town) (State) (Phone)

EMPLOYER'S STATEMENT

Employee's name.		
On what date did he first quit work entirely?	_____ , 20__	On what date did he resume any part of his work, supervisory or otherwise? _____, 20__
Was injury or disease covered under Workmen's Compensation?	Yes___ No___ (If "yes" give name and address of your compensation carrier)	
Date _____, 20__	Signature of Employer _____	(Title)
Phone No. _____	Address _____ (Street Address) (City or Town) (State)	