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MEDICAL PROVIDER QUESTIONNAIRE

To be completed by the Patient's treating physician or other licensed medical provider. If completed by a medical provider other than a physician, if possible, please have the supervising physician review the information provided and sign where indicated at the bottom of the form. If additional space is needed to complete any question, please attach additional pages as necessary to complete your responses.

Patient's Name: _____

Patient's primary diagnosis: _____

Any secondary diagnosis: _____

Initial Date Seen: _____ Last Date Seen: _____ Next Appointment: _____

Treatment Plan: _____

_____

_____

Medications with dosage information: _____

_____

In your opinion is the Patient medically unable to work at this time? Yes _____ No _____

If Yes, symptoms preventing work: _____

_____

_____

If Yes, estimated return to work date: _____

I certify that the above information is true and correct.

_____ _____
Medical Provider's Signature Date

_____ _____
Medical Provider's Name and Title (Please Print) Direct Telephone Number

_____
Supervisory Physician's Signature (If applicable)