

**APPLICATION FOR DISABILITY LEAVE BENEFITS - ATTENDING PHYSICIAN STATEMENT**  
 Instructions for completing this form are on Page 1 of this application.

**PLEASE ATTACH COPIES OF OFFICE NOTES, EVALUATIONS, AND TESTING RESULTS.  
 INSUFFICIENT AND/OR ILLEGIBLE MEDICAL EVIDENCE MAY RESULT IN THE DENIAL OF BENEFITS.**

**Employee - Section A (Employee, complete this section before giving the form to your provider)**

Employee Name	Date of Birth	State of Ohio User ID
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**Attending Physician/Treating Provider - Section B  
 (Employee is prohibited from completing any portion of this form beyond this point)**

Date patient rendered disabled from working	Ever had same or similar condition: Yes ___ No ___ If yes, when and describe
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Is condition arising out of employment? Yes \_\_\_ No \_\_\_

Date first consulted you for this condition	Additional dates of treatment including the most recent visit
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Frequency of visits: Weekly ___ Monthly ___ Other ___	Referrals
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Date of most recent visit	Next scheduled appointment	EDC
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**Diagnosis of disabling condition(s)**

Primary Diagnosis _____	ICD-10 _____
Secondary Diagnosis _____	ICD-10 _____
Tertiary Diagnosis _____	ICD-10 _____

Dates of Hospitalization	Name of Hospital
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Reason for hospitalization and/or type of surgery performed	If surgery performed, give date Mo ___ Day ___ Yr ___	If pregnancy, provide delivery date Mo ___ Day ___ Yr ___
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**Complications or other factors delaying recovery (describe)**

**Subjective symptoms.** (If psychiatric, describe mood and affect, ability to relate, ability to carry out daily activities, follow instructions, judgment, and ability to concentrate)

Medications	Dosage	Date initiated
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Employee Name																																	
Plan of treatment for a return to work																																	
What restrictions are placed on patient's work activities?																																	
What job duties is the patient unable to perform?																																	
<p>1. In an 8-hour workday, person can: (mark full capacity for each activity)</p> <p>TOTAL (hours)    Sit: 0 1 2 3 4 5 6 7 8            Stand: 0 1 2 3 4 5 6 7 8            Walk: 0 1 2 3 4 5 6 7 8</p>																																	
<p>2. Person can lift and carry:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;"></td> <td style="width:12.5%; text-align:center;">Never</td> <td style="width:12.5%; text-align:center;">Occasionally (1%-33%)</td> <td style="width:12.5%; text-align:center;">Frequently (34%-66%)</td> <td style="width:12.5%; text-align:center;">Constantly (67%-100%)</td> </tr> <tr> <td>Up to 10 lbs.</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> </tr> <tr> <td>11-20 lbs.</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> </tr> <tr> <td>21-50 lbs.</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> </tr> <tr> <td>51-100 lbs.</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> </tr> <tr> <td>Over 100 lbs.</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> </tr> </table>					Never	Occasionally (1%-33%)	Frequently (34%-66%)	Constantly (67%-100%)	Up to 10 lbs.	_____	_____	_____	_____	11-20 lbs.	_____	_____	_____	_____	21-50 lbs.	_____	_____	_____	_____	51-100 lbs.	_____	_____	_____	_____	Over 100 lbs.	_____	_____	_____	_____
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<p>3. Person can push/pull:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;"></td> <td style="width:12.5%; text-align:center;">Never</td> <td style="width:12.5%; text-align:center;">Occasionally (1%-33%)</td> <td style="width:12.5%; text-align:center;">Frequently (34%-66%)</td> <td style="width:12.5%; text-align:center;">Constantly (67%-100%)</td> </tr> <tr> <td>Up to 10 lbs.</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> </tr> <tr> <td>11-20 lbs.</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> </tr> <tr> <td>21-50 lbs.</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> </tr> <tr> <td>51-100 lbs.</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> </tr> <tr> <td>Over 100 lbs.</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> <td style="text-align:center;">_____</td> </tr> </table>					Never	Occasionally (1%-33%)	Frequently (34%-66%)	Constantly (67%-100%)	Up to 10 lbs.	_____	_____	_____	_____	11-20 lbs.	_____	_____	_____	_____	21-50 lbs.	_____	_____	_____	_____	51-100 lbs.	_____	_____	_____	_____	Over 100 lbs.	_____	_____	_____	_____
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<p>4. Person can do repetitive movements as in operating controls:</p> <p>Right hand/arm    ___ Yes    ___ No    Left hand/arm    ___ Yes    ___ No</p>																																	
<p>5. Other restrictions:</p>																																	
<p><b>Patient's condition prevents them from working:</b></p> <p><b>Temporarily</b> ___    <b>For longer than 12 months</b> ___    <b>Permanently</b> ___</p> <p>If disability is temporary, patient's estimated date of release to return to work:</p> <p>___ For regular occupation            Mo. ___ Day ___ Yr. ___</p> <p>___ On a part-time basis                Mo. ___ Day ___ Yr. ___</p> <p>Part-time schedule:                    Hours per day ___ Days per week ___ # of weeks ___</p> <p>___ For suitable work activities within the limitations listed above    Mo. ___ Day ___ Yr. ___</p>																																	
<b>Additional Remarks</b>																																	
<b>PLEASE PRINT</b> Name (treatment provider)		Specialty	Fed ID#																														
Street Address		City	State            ZIP Code																														
Telephone (area code)	Fax (area code)		Email Address																														
Date form received	Date signed	Signature																															