Attending Physician's Statement of Disability

COUNTY OF SAN MATEO
Risk Management Division
455 County Center, 5th Fl
Redwood City, CA 94063

Name of patient (print)	Date of birth
Present address (number, street, city, state or province, zip code)	

1. History

a. When did symptoms first appear or accident happen? (mo/day/yr)	b. Date patient ceased work because of disability (mo/day/yr)
c. Has patient ever had same or similar condition? (if "yes," state when and describe) ☐ Yes ☐ No	

2. Present Condition

a. Is the patient competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No
b. Subjective symptoms
c. Objective findings (include results of current X-rays, E.K.G.'s or any other special tests)
d. Is patient... ☐ Ambulatory? ☐ Bed confined? ☐ House confined? ☐ Hospital confined?
e. Date of most recent surgery: Type of surgery:

3. Diagnosis

4. Treatment

a. Date of first visit (mo/day/yr)	b. Date of last visit (mo/day/yr)
c. Frequency of visits ☐ Weekly ☐ Monthly ☐ Other_____	d. When did you last examine the patient (mo/day/yr)

5. Progress

☐ Recovered	☐ Improved	☐ Unimproved	☐ Retrogressed	☐ Stable

6. Extent of Disability

a.	Is patient totally disabled... FOR ANY OCCUPATION? ☐ Yes ☐ No	if no, when was patient able to go to work? (mo/day/yr)
b.	FOR PATIENT'S REGULAR OCCUPATION? ☐ Yes ☐ No	if yes, when do you think patient will be able to resume work? ☐Approximate date (mo/day/yr) _____ ☐ Indefinite date (mo/day/yr) _____ ☐ Never
c.	Is patient a suitable candidate for a rehabilitation program? ☐Yes ☐ No (If "yes," please elaborate)	

Complete appropriate section, ONLY if disability is due to CARDIAC CONDITION or VISUAL IMPAIRMENT

7. Cardiac

a. Functional capacity (American Heart Ass'n.) ☐ Class 1 (No limit) ☐ Class 3 (Marked limitation) ☐ Class 2 (Slight limitation) ☐ Class 4 (Complete limitation)	b. Blood pressure

8. Visual Impairment

a. What was vision at last observation?

With glasses: O.D._____ O.S._____ Mo._____ Day_____ Year _____

Without glasses: O.D._____ O.S._____ Mo._____ Day_____ Year_____

b. Date corrected vision was irrecoverable reduced to 20/200 or less in the better eye (mo/day/yr)

☐ O.D. ☐ O.S.

c. Vision can be restored in whole or in part by:

O.D. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not restorable

O.S. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not restorable

REMARKS:

COMPLETED BY:

Signature (Attending physician)	Degree:	Date:
Attending physician's name (Please print):	Address (City, State, Zip):	
Tax I.D. #:	Phone #:	