DISABILITY CERTIFICATE

Patient Name **Date of Birth** **Date of Injury**

Diagnosis: _____

I have examined and/or treated the above-named patient for injuries sustained in the aforementioned accident. As a result of these injuries, I have disabled the patient from those activities that are marked with an "**X**."

1. _____ **HOUSEWORK / REPLACEMENT SERVICES:** As some housework may involve **bending, lifting, twisting, and prolonged standing** as required by vacuuming, making beds, washing floors, sinks, bathtubs, toilets, moving furniture, picking up objects off the floor, carrying garbage or groceries. It is my opinion that the patient is/was disabled from _____to _____.

2. _____ **DRIVING / TRANSPORTATION:** The Patient is unable to drive and requires transportation services. It is my opinion that the patient is/was disabled from _____to _____.

3. _____ **ATTENDANT CARE:** Which is in-home services provided by a family member or friend as would a R.N., L.P.N., or nurse's aide, that involves helping a patient with a broad range of personal needs which may **bending, lifting, twisting, and prolonged standing** as required by safety supervision, ambulation assistance, transferring, positioning, emotional assistance, bathing assistance, dressing assistance, grooming assistance, toileting assistance, transportation, eating, meal preparation, medication management, management of finances, bandage, wound care, hygiene assistance, physical therapy assistance, and other similar assistance. It is my opinion that the patient is/was disabled from _____ to _____for _____**hours / day** _____ **days / week**.

4. _____ **WORK LOSS:** As employment may involve **bending, lifting, twisting, and prolonged standing.** It is my opinion that the patient is/was disabled from _____to _____.

WORK RESTRICTIONS: The patient is restricted from **bending, twisting, and prolonged standing and lifting objects that weight more than _____ pounds.**

5. _____ **RETURN TO WORK:** The patient may return to work on _____.

6. _____ **CASE MANAGEMENT:** It is my opinion that the patient requires case management from _____to _____.

_____ _____

Date: **Signature of Physician**

_____

Name of Physician - Print