

**B**

# PHYSICIAN STATEMENT

PLEASE PRINT CLEARLY

1. Patient's Full Name \_\_\_\_\_

2. Diagnosis \_\_\_\_\_

3. Patient is unable to work from \_\_\_\_\_ to \_\_\_\_\_. (light duty not available)

ATTENDING PHYSICIAN \_\_\_\_\_ MD

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Federal Tax No. \_\_\_\_\_ Telephone \_\_\_\_\_

Date \_\_\_\_\_ Signed \_\_\_\_\_

