

ID CASUAL

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 _____