



ATTENDING PHYSICIAN'S STATEMENT
*THE PATIENT IS RESPONSIBLE FOR THE COMPLETION
OF THIS FORM WITHOUT EXPENSE TO THE COMPANY.*
USE REVERSE SIDE FOR ADDITIONAL COMMENTS

Name of patient	Date of Birth (Mo/Day/Yr)		
Employer Name	Group/Policy Number		
1. History			
a) When did symptoms first appear or accident happen?	Month	Day	Year
b) Date patient ceased work because of disability	Month	Day	Year
c) Has patient ever had same or similar condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "yes" state when and describe
d) Is condition due to injury or sickness arising out of patient's employment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
e) Names and addresses of other treating physicians:			
2. Diagnosis (including any complications)			
a) Date of last examination?	Month _____	Day _____	Year _____
b) Diagnosis (including any complications)			
c) Subjective symptoms:			
d) Objective findings (Including current X-Rays, EKG's, Laboratory Data and any clinical findings)			
3. Dates of Treatment			
a) Date of first visit?	Month	Day	Year
b) Date of last visit?	Month	Day	Year
c) Frequency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Other (Specify)
4. Nature of treatment (including Surgery and Medications prescribed, if any)			
5. Progress			
a) Has patient	<input type="checkbox"/> Recovered?	<input type="checkbox"/> Improved?	<input type="checkbox"/> Unchanged?
b) Is patient	<input type="checkbox"/> Ambulatory?	<input type="checkbox"/> House confined?	<input type="checkbox"/> Retrogressed?
	<input type="checkbox"/> Bed confined?	<input type="checkbox"/> Hospital confined?	
6. Cardiac (If applicable)			
a) Functional capacity	<input type="checkbox"/> Class 1 (No limitation)	<input type="checkbox"/> Class 2 (Slight limitation)	
	<input type="checkbox"/> Class 3 (Marked limitation)	<input type="checkbox"/> Class 4 (Complete limitation)	
b) Blood pressure (last visit)	_____		
	Systolic/Diastolic		
7. Physical Impairment (*as defined in Federal Dictionary of Occupational Titles)			
<input type="checkbox"/> Class 1	No limitation of functional capacity; capable of heavy work No restrictions (0-10%)		
<input type="checkbox"/> Class 2	Medium manual activity (15- 30%)		
<input type="checkbox"/> Class 3	Slight limitation of functional capacity; capable of light work* (35-55%)		
<input type="checkbox"/> Class 4	Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%)		
<input type="checkbox"/> Class 5	Sever limitation of functional capacity; incapable of minimal (sedentary) activity. (75 – 100%)		
<input type="checkbox"/> Remarks:			



**NORTH CAROLINA MUTUAL
LIFE INSURANCE COMPANY**

8. Mental/Nervous Impairment (if applicable)

a) Please define "stress" as it applies to this claimant

b) What stress and problems in interpersonal relations has claimant had on job?

Class 1 Patient is able to function under stress and engage in interpersonal relations (no limitations)

Class 2 Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)

Class 3 Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)

Class 4 Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)

Class 5 Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks:

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? Yes No

9. Prognosis

a) Is patient now totally disabled? **Patient's Job** Yes No **Any Other Work** Yes No

b) What duties of patient's job is he/she incapable of performing?

Do you expect a fundamental or marked change in the future? Yes No Yes No

1) If yes, when will patient recover sufficiently to perform duties? Mo/Day/Yr 1 Mo. 3-6 Mo. Mo/Day/Yr 1 Mo. 3-6 Mo.
 1-3 Mo. Never 1-3 Mo. Never

2) If no, please explain...

10. Rehabilitation

a) Is patient a suitable candidate for further rehabilitation services? (i.e., cardiopulmonary program, speech therapy, etc.) Yes No

b) Can present job be modified to allow for handling with impairment? Yes No

c) When could trial employment commence? **Patient's Job** Mo/Day/Yr Full Time Mo/Day/Yr Full Time
 Part Time Part Time

d) Would vocational counseling and/or retraining be recommended? Yes No

11. Remarks

Name (Attending Physician) Print	Degree	Telephone
Street Address	City	State Zip
Signature	Date	