

# DISABILITY FORMS

TO BE COMPLETED BY PATIENT WHEN SUBMITTING DISABILITY FORMS

*PLEASE NOTE: Forms are completed AFTER surgery and are completed on a weekly basis.*

*Questions: Please call Jamie Scannella at 609-537-6747 Fax: 609-537-6002*

WE APPRECIATE YOUR PATIENCE. THANK YOU.

PATIENT'S NAME \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

LAST DATE OF WORK \_\_\_\_\_ TYPE OF WORK \_\_\_\_\_

DOES YOUR JOB REQUIRE HEAVY LIFTING? \_\_\_\_\_

TYPE OF SURGERY \_\_\_\_\_

DATE OF SURGERY \_\_\_\_\_

DOCTOR PERFORMING SURGERY \_\_\_\_\_

EXPECTED DATE OF RETURN TO WORK \_\_\_\_\_

## WHEN FORMS ARE COMPLETED:

Please check off:

MAIL TO:      Patient                       Insurance Company                       Employer

Address: \_\_\_\_\_

FAX TO:      Patient                       Insurance Company                       Employer

FAX #: \_\_\_\_\_