

**SECTION B- ATTENDING PHYSICIANS SUPPLEMENTARY STATEMENT**

**Claimant's Name** \_\_\_\_\_

**Please answer all questions**

1. Nature of sickness or injury and complications if any causing disability? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. What operations, if any, were performed since last statement? \_\_\_\_\_

3. Give all dates of treatment since last statement? Home \_\_\_\_\_ Office \_\_\_\_\_

4. Was claimant hospitalized since last statement? \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
Name and Address of Hospital: \_\_\_\_\_

5. Have any other physicians been in attendance or consultation since last statement? \_\_\_\_\_  
If yes give their name and addresses: \_\_\_\_\_  
\_\_\_\_\_

6. Current limitations and restrictions, if any: \_\_\_\_\_  
\_\_\_\_\_

7. **Is this claimant totally disabled from each and every occupation?** \_\_\_\_\_  
**If no, please explain:** \_\_\_\_\_  
\_\_\_\_\_

8. (a) **How long was or will claimant be totally disabled from current occupation?** From \_\_\_\_\_ To \_\_\_\_\_  
(b) **How long was or will claimant be partially disabled from current occupation?** From \_\_\_\_\_ To \_\_\_\_\_  
(c) **Estimated return to work date:** \_\_\_\_\_

9. What is the prognosis? \_\_\_\_\_  
\_\_\_\_\_

**Doctors Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Doctors Name (please print or type)** \_\_\_\_\_ **Tel #**(      ) \_\_\_\_\_

**Office Address** \_\_\_\_\_  
**Number**                      **Street**                      **City or Town**                      **State**                      **Zip Code**