ATTENDING PHYSICIAN'S STATEMENT

CLAIM FOR BENEFITS SUBMITTED TO COMMUNITY COLLEGE OF PHILADELPHIA

1700 Spring Garden Street
Philadelphia, PA 19130

Attention: Office of Human Resources
Phone: 215-751-8038 Fax: 215-972-6307

FORM DUE to HR: _________________

NAME OF PATIENT (PRINT): **DATE OF BIRTH** **Social Security No:**

XXX – XX - ___________

PRESENT ADDRESS NO. STREET CITY STATE ZIP CODE

My signature below releases my attending physician(s) to converse with or provide detailed information to the Office of Human Resources at Community College of Philadelphia concerning my medical condition(s). I hereby release my health care practitioners to provide any and all information to representatives of the College which is deemed necessary by the College in order to make informed determinations concerning my eligibility for approved medical leave. This may include, but is not limited to, diagnosis, prognosis and course of treatment.

Signature: **Date:**

ATTENDING PHYSICIAN'S STATEMENT OF MEDICAL CONDITION

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

The patient is responsible for the completion of this form without expense to the College. Space is available on the reverse side if you wish to amplify your answers.

1. **DIAGNOSIS** (including any complication)

(a) Diagnosis MONTH, DAY, YEAR

MONTH	DAY	YEAR

(b) When did symptoms first appear or accident happen?

(c) Date patient ceased work because of medical condition:

(d) Date of last examination:

(e) Subjective symptoms:

(f) Objective findings (including current X-rays, EKGs, Blood Pressure, Laboratory Data and any clinical findings):

(g) In your view, did condition arise, in full or in part, out of patient's employment? ☐ Yes, in full ☐ Yes, in part ☐ No

2. DATES OF TREATMENT

(a) Date of first visit .... Month ___________________________ Day __________________________ Year _____________

(b) Date of last visit .... Month ___________________________ Day __________________________ Year _____________

(c) Frequency ....Weekly ☐ Monthly ☐ Other (specify): ☐ ____

3. NATURE OF TREATMENT (Including surgery and medications prescribed, if any)

4. PROGRESS

(a) Has patient .... ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

(b) Is patient .... ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

If patient has been hospital confined, give name and address of Hospital ____

____ Confined from _____________________________ through _____________________________

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5. PHYSICAL IMPAIRMENT

☐ Class 1 – No limitation of functional capacity, capable of heavy physical activity. No restrictions. (1-10%)

☐ Class 2 – Slight limitation of functional capacity, capable of light manual activity. (15-30%)

☐ Class 3 – Moderate limitation of functional capacity, capable of clerical/administrative (sedentary) activity. (35-55%)

☐ Class 4 – Marked limitation. (60-70%)

☐ Class 5 – Severe limitation of functional capacity, incapable of minimal (sedentary) activity. (75-100%)

If applicable, please provide remarks below: Section 8.

6. MENTAL /NERVOUS IMPAIRMENT (IF APPLICABLE)

☐ Class 1 – No significant limitation of functional capacity; able to perform requirements of the job. (No limitations)

☐ Class 2 – Some limitation of functional capacity; capable of performing requirements of the job on a part-time or intermittent basis, or to perform alternative tasks. (Moderate limitations)

☐ Class 3 – Severe limitations of functional capacity; incapable of performing job requirements or any alternative tasks. (Severe limitation.)

(If applicable, please provide remarks below: Section 8

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

7. PROGNOSIS (complete with respect to PATIENT'S JOB)

PATIENT'S JOB

(a) Is patient now totally **unable** to work? .... ☐ Yes ☐ No

(b) Do you expect a meaningful change in the future? ☐ Yes ☐ No

(1) If yes, when will patient recover sufficiently to perform duties: ________/________/________
Month Day Year

IF DATE OF RECOVERY IS UNCERTAIN, PLEASE PROVIDE ESTIMATED DATE.

(2) If no, please explain:

(c) Re-evaluation is recommended on: ________/________/________
Month Day Year

8. REMARKS

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Print Here (Attending Physician) **Degree** **Telephone**

____

Street Address **City or Town** **State** **ZIP CODE**

____

Signature **Date**

____