

**ATTENDING PHYSICIAN'S STATEMENT**

(To Be Completed by Physician)

The patient is responsible for completion of this form without expense to the District.  
**IMPORTANT: Items 7 and/or 8, if applicable, must be completed on reverse side.**

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo. Day Yr.

Address \_\_\_\_\_  
No. Street City State Zip Code

Name of Employer ROCHESTER CITY SCHOOL DISTRICT Health Insurance Group/Policy No. \_\_\_\_\_

**1 HISTORY**

- (a) When did symptoms first appear or accident happen? Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
- (b) When did patient cease work because of disability? Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
- (c) Has patient ever had same or similar condition?  Yes  No  
If "Yes" state when and describe. \_\_\_\_\_
- (d) Is condition due to injury or sickness arising out of patient's employment?  Yes  No  Unknown
- (e) Names and addresses of other treating physicians? \_\_\_\_\_

**2 DIAGNOSIS (Including any complications)**

- (a) Date of last examination: Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
- (b) Diagnosis (including any complications): \_\_\_\_\_
- (c) Subjective symptoms: \_\_\_\_\_
- (d) Objective findings (including diagnosis of current X-rays, EKG's, Laboratory Data and any clinical findings):  
\_\_\_\_\_

**3 DATES OF TREATMENT**

- (a) Date of first visit: Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
- (b) Date of last visit: Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
- (c) Frequency:  Weekly  Monthly  Other  Specify

**4 NATURE OF TREATMENT (Including surgery, physical therapy, counseling, and medications prescribed, if any.)**

**5 PROGRESS**

- (a) Has patient  Recovered?  Improved?  Stabilized?  Retrogressed?
- (b) Is patient  Ambulatory?  House Confined?  Bed Confined?  Hospital Confined?
- (c) Has patient been hospital confined?  Yes  No If "Yes" give name and address of hospital.  
\_\_\_\_\_ Confined from \_\_\_\_\_ through \_\_\_\_\_

(over)

**6 CARDIAC (If Applicable)**

- (a) Functional capacity (American Heart Assoc.)  **Class 1** (No Limitation)  **Class 2** (Slight Limitation)  
 **Class 3** (Marked Limitation)  **Class 4** (Complete Limitation)
- (b) Blood Pressure (last visit)      Systolic \_\_\_\_\_      Diastolic \_\_\_\_\_

**7 PHYSICAL IMPAIRMENT (As defined in Federal Dictionary of Occupational Titles)**

- Class 1 ↘ No limitation of functional capacity: capable of heavy work. No restrictions (0-10%).
- Class 2 ↘ Medium minimal activity (15-30%).
- Class 3 ↘ Slight limitation of functional capacity: capable of light work (35-55%).
- Class 4 ↘ Moderate limitation of functional capacity: capable of clerical/administrative (sedentary) activity (60-70%).
- Class 5 ↘ Severe limitation of functional capacity: incapable of minimal (sedentary) activity (75-100%).

**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 limitations and engage in most interpersonal relations (slight limitations).  
Patient is able to engage in only limited stress situation and engage in only limited interpersonal relations (moderate limitations).
- Class 3 ↘ Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations).
- Class 4 ↘ Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations).

**9 PROGNOSIS**

Expected Return to Work Date: \_\_\_\_\_

**10 REMARKS**

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Attending Physician Name (PRINT)	Degree	Specialty	Telephone No.
Address	City or Town		State
Signature		Date	

**Please Return Completed Form c/o:  
 Rochester City School District ♦ Employee Benefits ♦ 131 West Broad Street ♦ Rochester, New York 14614**