CORE BENEFITS INC.
Quality, Compliance & Service

10319 Dawson's Creek Blvd, Ste C
Fort Wayne, IN 46825
Phone: (260) 492-7451
Fax: (260) 492-7292

ATTENDING PHYSICIAN'S STATEMENT

1. Name of Patient	2. Social Security Number	3. Employer Name
4. When did symptoms first appear or accident happen?	5. Date you believe patient was unable to work?	
6. Diagnosis (including complications)	7. Subjective symptoms	
8. Objective findings (including x-rays, EKG's, laboratory data and any clinical findings)		
9. List of Restrictions & Limitations		
10. Nature of treatment (including surgery and medications prescribed if any)		
11. Names, specialty and addresses of other treating physicians		
12. Has patient ever had same or similar conditions? ☐Yes ☐No If "Yes" provide dates		
13. Do you consider this condition to be due to your patient's employment? ☐Yes ☐No		
14. If pregnancy, estimated date of delivery: Actual date of delivery:	15. Date first treated:	16. Date of last visit/treatment:
17. Frequency ☐Weekly ☐Monthly ☐Other (specify):		
18. Has patient: ☐Recovered ☐Improved ☐Unchanged ☐Regressed	19. Is patient: ☐Ambulatory ☐House Confined ☐Bed Confined ☐Hospital Confined	
20. Has patient been hospital confined? ☐Yes ☐No Confined from: to: If "Yes" give name of hospital:		
21. Has surgery been scheduled or performed? ☐Yes ☐No If "Yes" date of surgery: Type of surgery scheduled:		
22. Prognosis and Rehabilitation: a. When do you think your patient will be able to return to work? PRESENT occupation? ALL OTHER occupations? b. Can present job be modified to allow patient to handle with his/her impairment? ☐Yes ☐No c. When could trial employment commence? ☐Full-time ☐Part-time Please submit clinical documentation to support your decision.		
Print Name (Attending Physician)	Specialty:	Telephone (Include Area Code)
Street Address/City or Town/State or Province/Zip Code		
Signature (Attending Physician) No stamps please.	Date:	Fax Number (Include Area Code)