



# ATTENDING PHYSICIAN'S STATEMENT

State Form 45547 (R7 / 7-17)

STATE OF INDIANA  
STATE PERSONNEL DEPARTMENT  
Benefits Division, Disability Program

Mail completed form to: JWF Specialty Co., Inc. (Third Party Administrator)  
PO Box 40968  
Indianapolis, IN 46240-0968  
Telephone: (888) 818-7795  
Fax: (866) 893-4674

This form is confidential per IC 5-14-3-4(A) (9).

<b>This form is to be completed without expense to the State of Indiana.</b>	
<b>THIS SECTION IS TO BE COMPLETED BY EMPLOYEE / PATIENT (Please print.)</b>	
Name of patient	Date of birth (month, day, year)
Name of agency	
Job title	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>THIS SECTION IS TO BE COMPLETED BY PHYSICIAN</b>	
<b>I. HISTORY</b>	
a.) When did symptoms first appear or accident happen?	
b.) Has the patient ever had the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If Yes, state when and describe.
c.) Name(s) and address(es) of other treating physician(s).	
Is the condition due to injury or sickness arising from patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>II. DIAGNOSIS</b>	
a.) Diagnosis (including any complications)	
b.) CPT code	
c.) If pregnancy, estimated date of delivery (month, day, year)	
d.) Subjective symptoms	
e.) Objective findings (including current x-rays, EKGs, laboratory data and clinical findings)	
<b>III. TREATMENT</b>	
a.) Date of first visit (month, day, year)	b.) Date of last visit (month, day, year)
c.) Frequency of treatment: Weekly _____; Monthly _____; Other (specify): _____	
d.) Nature of treatment (including surgery and medications prescribed, if any)	
e.) Has the patient been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No	f.) If yes, dates confined from / through (month, day, year)
Name and address of hospital	

<b>IV. PHYSICAL IMPAIRMENT (* As defined in federal dictionary of occupational titles.)</b>			
<input type="checkbox"/> Class 1 - No limitation of functional capacity; capable of heavy work. No restrictions * (0-10%) <input type="checkbox"/> Class 2 - Medium manual activity * (15- 30%) <input type="checkbox"/> Class 3 - Slight limitation of functional capacity; capable of light work * (35- 55%) <input type="checkbox"/> Class 4 - Moderate limitation of functional capacity; capable of clerical / administrative (sedentary) activity * 60- 70%) <input type="checkbox"/> Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity * (75- 100%) <input type="checkbox"/> Other limitations: _____			
<b>V. MENTAL / NERVOUS IMPAIRMENT (If applicable.)</b>			
a.) Please define "stress" as it applies to this claimant			
b.) What stress and problems in interpersonal relations has claimant had on job?			
<input type="checkbox"/> Class 1 – Patient is able to function under stress and engage in interpersonal relations (no Limitations) <input type="checkbox"/> Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations) <input type="checkbox"/> Class 3 – Patient is able to engage in only limited stress situations and engage in limited interpersonal relations (moderate limitations) <input type="checkbox"/> Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations) <input type="checkbox"/> Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations) <input type="checkbox"/> Other limitations: _____			
<b>V. WORK STATUS</b>			
a.) Date patient became totally disabled from this condition ( <i>month, day, year</i> )		b.) Anticipate return to work date?	
<b>VI. REMARKS</b>			
<i>(Limitations, therapy, etc.)</i>			
<p>I declare that I have examined this report and the statement contained herein is to the best of my knowledge and belief true, correct, and complete. I further understand that a fraudulent misstatement in completing this form would result in a loss of benefits for my patient. <i>Do not provide any genetic information when responding to this request.</i></p>			
Signature of attending physician		Date of last visit ( <i>month, day, year</i> )	
Printed name	Degree	Telephone number (      )	
Address ( <i>number and street, city, state, and ZIP code</i> )			