

Phone:

Fax:

Member Name:
Docket Number:
PACSES Case Number:
Other State ID Number:

Please note: All correspondence must include the PACSES Case Number.

PHYSICIAN'S INFORMATION REQUEST

TO BE COMPLETED BY ATTENDING PHYSICIAN:

Physician's Name: _____

Nature of patient's sickness or injury (Describe complications, if any)

- (a) Date of first treatment: _____
- (b) Date of most recent treatment: _____
- (c) Frequency of treatments: _____
- (d) Medication: _____

The patient has been continuously disabled (unable to work) from:
_____ through _____

If still disabled, when should patient be able to return to work? Are there limitations?

REMARKS: _____

Date: _____ Signed: _____
(Attending Physician)

**I hereby authorize my physician to
release the above information to
the _____ County
Domestic Relations Section**

Physician's Address

Patient's Signature

Date