COUNTY OF BERKS ATTENDING PHYSICIAN STATEMENT

1. PATIENT INFORMATION

Name: **Birth Date:**

Address:

2. TREATMENT INFORMATION

Primary Diagnosis:

Are you currently treating this patient?

Date first treated for this condition: **Date of patient's last visit:**

3. PROGRESS

Patient has:	**Recovered**	________	**Not Changed**	________
	Improved	________	**Retrogressed**	________
			Other	__________________
Patient is:	**Ambulatory**	________	**House Confined**	________
	Bed Confined	________	**Hospital Confined**	________
			Other	__________________

Have you placed patient on a "off-work" status? ___ Yes ___ No
If yes, what date? ____/ ____/ ____

If patient is not released to return to work, when do you anticipate a release? ____/ ____/ ____

4. PHYSICIAN INFORMATION

Physician's Name:
Office Address:

Telephone #: **Fax#**

Degree/Speciality:

I, ______________________________, (Physician Name) verify that the facts set forth in the foregoing are true and correct, to the best of my knowledge, information, and belief. I understand that the statements contained herein are made subject to the penalties of 18 PA C.S.A. Section 4904 relating to unsworn falsification to authorities.

____ ____/____/____
Physician Signature Date

PLEASE RETURN THIS COMPLETED FROM TO: PATIENT OR BERKS COUNTY TAX CLAIM, HARDSHIP PROGRAM, 633 COURT STREET, 2ND FL, READING, PA 19601
TELEPHONE (610-478-6625)