

TO: _____
(Physician)

DATE _____

FROM: JOHN S. KEARNS
(Social Worker)

RE: - _____
(Applicant)

SSN: _____

SUBJECT: Disability Evaluation Relative to Employment

The above named applicant has been examined by me and has the following diagnosis (If psychiatric, the DSM III code must be included)

- [] In my opinion this person is capable of full employment
- [] In my opinion this person is capable of light duty employment only
- [] In my opinion this person is incapable of any employment and is estimated to be disabled for _____ number of months disabled. **Be as specific as possible.**
- [X] In my opinion this person is totally and permanently disabled.
- [X] Is applicant advised to apply for SSI/SSD?

If estimated period of disability is twelve (12) months or longer, the individual will be required to apply for SSI/ SSD/ Medicaid.

(Physician Signature)

(Physician Name Print)

(Physician Address)

(Physician Phone Number)

(Date Form Completed)