PHYSICIAN'S STATEMENT

DOCTOR'S NAME ADDRESS PHONE

NAME OF PATIENT: _____

IS THIS DISABILITY DUE TO PREGNANCY?
YES _____ NO _____

EXPECTED DATE OF CONFINEMENT: _____

DURING THIS PREGNANCY, IF YOU RECOMMEND THAT THIS PATIENT BE OFF WORK, PLEASE GIVE THE MEDICAL REASON AND TIME THE PATIENT SHOULD BE OFF:

IF CHANGE IS CHECKED ON SUBSEQUENT VISITS BELOW, PLEASE STATE MEDICAL REASON FOR SICKNESS AND DATES

DATE VISIT	NO CHANGE	CHANGE	INITIALS	COMMENTS, MEDICAL DIAGNOSIS, OR RECOMMENDATIONS FOR MEDICAL COMPLICATIONS OF PREGNANCY (TIME OFF FROM WORK).

DATE OF DELIVERY: _____

NUMBER OF DAYS YOU HAVE RECOMMENDED TO PATIENT TO BE OFF FOR SICKNESS DISABILITY:

BEFORE DELIVERY: FROM _____ TO _____
AFTER DELIVERY: FROM _____ TO _____

ADDITIONAL COMPLICATIONS OR COMMENTS: _____

ATTENDING PHYSICIAN'S SIGNATURE: _____