In the Court of Common Pleas of **County, Pennsylvania**

Phone: **Fax:**

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

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

PHYSICIAN VERIFICATION FORM

TO BE COMPLETED BY THE TREATING PHYSICIAN:

Physician's Name: _____

Physician's License Number: _____

Nature of patient's sickness or injury:

_____

_____

_____

(a) Date of first treatment: _____

(b) Date of most recent treatment: _____

(c) Frequency of treatments: _____

(d) Medication: _____

The patient has had a medical condition that affects his or her ability to earn income from:

_____ through _____

If the patient is unable to work, when should the patient be able to return to work? Will there be limitations?

_____

_____

REMARKS: _____

_____

Date: _____ Signed: _____
Signature of Treating Physician

_____
Physician's Address

_____

_____
Physician's Telephone Number

I authorize my physician to release the above information to the County Domestic Relations Section.

_____ _____
Patient's Signature **Date**

Service Type

Form EN-015 07/15
Worker ID

In the Court of Common Pleas of ADAMS County, Pennsylvania
DOMESTIC RELATIONS SECTION
525 Boyds School Rd. Suite 600, Gettysburg, PA 17325

PHYSICIAN'S INFORMATION REQUEST

ADDENDUM TO BE COMPLETED BY ATTENDING PHYSICIAN:

Describe how the patient's sickness, injury, or disability currently affects the patient's work duties or prevents the patient from maintaining employment (whether full or part time)?

_____
_____
_____
_____
_____

If the patient is able to return to work with disability limitations, describe those limitations and indicate if and how those limitations prevent the patient from continuing previous work duties.

_____
_____
_____

If the patient's sickness, injury, or disability affects the patient's work duties or prevents the patient from maintaining employment (whether full or part time), might the patient be referred for treatment or evaluations to another practitioner (i.e. a specialist)?

_____
_____
_____

Is this patient a candidate for vocational rehabilitation? _____

Date: _____ Signed: _____
(Attending Physician)

TELEPHONE: (717) 337-9804
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