PLEASE HAVE COMPLETED BY YOUR DOCTOR AND FAX TO OUR OFFICE

TO: Caseworker: _____
Clermont County Child Support
Fax# 513-732-7444

RE: Disability Statement Concerning:
Name: _____
DOB: _____
SS#: _____
SETS Case # _____

The undersigned physician is licensed in the State of _____ and has treated the patient referenced above for [DESCRIBE DIAGNOSES AND/OR MEDICAL CONDITION(S) FOR WHICH YOU ARE TREATING THIS PATIENT AND/OR THOSE REFLECTED IN HIS/HER MEDICAL RECORDS AVAILABLE TO YOU AS A TREATING PHYSICIAN]:

_____
_____
_____

PLEASE CHECK ONLY ONE BLOCK AND COMPLETE REQUESTED INFORMATION.

1. UNABLE TO WORK BASED ON CURRENT DOCTOR/PATIENT INTERACTION:

☐ To a reasonable degree of medical certainty, I am of the opinion that the patient was unable to work from _____ to _____ as a result of the condition(s)/diagnoses listed above. Patient will be able to return to work on _____.

2. UNABLE TO WORK OPINION BASED ON REVIEW OF MEDICAL RECORDS:

☐ To a reasonable degree of medical certainty and following a review of the patient's medical records, I am of the opinion that the patient was unable to work beginning _____ due to the condition(s)/diagnoses in his/her records, which I have set out above.
- ☐ Patient will be able to return to work on _____.
- ☐ Patient will not be able to return to work.

3. ABLE TO WORK OPINION

☐ It is my opinion to a reasonable degree of medical certainty that the patient is NOT PREVENTED FROM WORKING due to the condition(s)/diagnoses listed above.

_____ _____
Physician's Signature Date

Printed Name of Physician:_____
Address:_____
City/State/Zip:_____

netDMS classification Legal/Discovery Response