

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

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

Physician's Address

Physician's Telephone Number

Patient's Signature

Date

