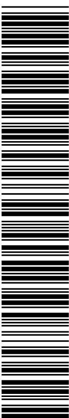


Phone: **Fax:**

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?

____

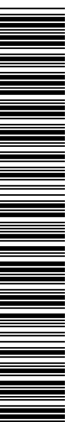
____

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**

Service Type

Worker ID