LONG-TERM DISABILITY INCOME PLAN (LTD)
City of San Diego
Risk Management Department (MS 51-B)

1200 Third Avenue, Suite 1000
San Diego, CA 92101
(619) 236-6100

Fax: (619)533-3203

Email: LTD@sandiego.gov

ATTENDING PHYSICIAN'S STATEMENT (PREGNANCY)

Please Read:

Pregnancy in itself is not considered a disabling condition. **Modified work, within the physical limitations, is available.** Each and every question must be answered. Form will be returned for incomplete answers, causing a delay in benefits for your patient.

Note: This form is to be completed at no cost to the City of San Diego

Instructions: Part A to be completed by employee.

Part B to be completed by your attending physician. Attending physician is physician(s) who is currently treating you for your pregnancy. If you have seen more than one physician for your pregnancy, a statement must be completed by each physician. Additional forms may be obtained from the LTD office (619)236-6100.

Your physician(s) should mail the completed form directly to the City of San Diego at the above address.

Part A: To be completed by employee (Please print or type).

Name _____
(Last) (First) (Middle)

Street Address _____

Mailing Address if other than street address _____

City _____ State _____ Zip _____

Home Telephone # (_____) _____ Job Classification _____

Email Address: _____

I authorize _____ to furnish
(Physician's Name, Medical Facility)

The Long-Term Disability Plan Representative, City of San Diego, at the above address all medical data they may request (including X-ray and laboratory reports) regarding diagnosis, care, and treatment for current disabling condition and/or alcohol, drug abuse, or mental health, if applicable, concerning my illness or injury.

This request pertains to my claim for City of San Diego's Employee's Long-Term Disability Income Plan and shall terminate 30 months from date of consent.

_____ _____
(Date) (Employee)

Part B: To be completed by Attending Physician (Please print or type).
Each and every question must be answered. Form will be returned for incomplete answers.

1. Diagnosis: _____ 2. ICD-CODE: _____

   Secondary Diagnosis (If Applicable); _____

3. Prognosis for remainder of pregnancy: _____ Excellent _____ Good _____ Poor

   Possibility of complications? _____. Why? _____

   _____

4. Date patient first consulted you for this condition? _____

   Date of latest examination _____

5. Are you familar with patients job duties? _____ Yes _____ No

6. Is patient now totally disabled from regular job?

   _____ No _____ Possibly _____ Probably _____ Definitely

   From _____ To _____

7. Estimated Date of Delivery _____

   Actual Delivery Date (If Known) _____

8. Name of Hospital _____

   Address _____

   Date Admitted _____ Date Discharged _____

   Admission Diagnosis _____

   Discharge Diagnosis _____

   Surgical Procedure (If Applicable) _____

The City of San Diego's Long-Term Disability Income Plan stipulates that medical treatment and medical disablement certification must be provided by a licensed physician.

Physician's Name _____ Telephone No. _____
(Please Type or Print)

Address _____

City _____ State _____ Zip _____

Physician's Signature _____ Date _____