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
Email: LTD@sandiego.gov

Fax 533-3203

ATTENDING PHYSICIAN'S STATEMENT

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 a physician who is currently treating you for your disability. If you have seen more than one physician for your disability, a statement must be completed by each physician. Additional forms may be obtained from the LT D Office (619)236-6100 or FAX to (619)533-3203.

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_____ Personal Email:_____

Street Address _____

City _____ State _____ Zip Code _____

Home Telephone No.: ( ) _____ Job Classification _____

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

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

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

_____ _____
(Date) (Employee Signature)

Part B: To be completed by an attending physician *(Please print or type your response answering each question below.)*

1. Diagnosis: _____ 2. ICD-CODE _____
3. Symptoms: _____
4. Date patient first consulted you for this condition? _____
5. Objective findings? (If none, please indicate so.) _____
6. History (Please provide a brief history and attach a narrative report, physicians' notes or operative reports if available.)
7. Is patient's condition related to employment? _____ Yes _____ No
   Is patient's condition related to mental or nervous condition? _____ Yes _____ No
   Is patient's condition related to alcohol or drug condition? _____ Yes _____ No

8. If patient has been confined to a hospital, please attach a copy of the operative report, if applicable.

   Name of Hospital _____

   Address _____

   Date Admitted _____ Date Discharged _____

   Admission Diagnosis: _____

   Surgical Procedure (if applicable): _____

9. Prognosis: _____ Retrogressed _____ Unimproved _____ Improved _____ Recovered

10. Medication: _____

11. Was/Is patient totally disabled from regular job? _____ Yes _____ No

    Dates disabled from regular job: From: _____ To: _____

12. **It is city policy to provide temporary light duty, or if necessary, alternate placement assistance to conform with work restrictions.**

    Can patient return to light duty? _____ Yes _____ No

    Please describe work restrictions: _____

    _____

    _____

    Date patient can return to light duty? _____

13. Date patient able to return to full duties of regular job? _____

14. Is patient totally disabled from any and all employment? _____ Yes _____ No

    Dates totally disabled: From: _____ To: _____

15. Frequency of visits? _____ Weekly _____ Biweekly _____ Monthly _____ Other

16. Please provide names and addresses of other treating physicians, if applicable.

Physician's Name	Address
_____	_____
_____	_____

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

Physician Name _____ Telephone No. _____

Address _____

City _____ State _____ Zip Code _____

FAX # _____

Physician Signature _____ Date _____