

Health Care Provider Evaluation

State your diagnosis(es) of the individual and/or provide a description of the individual's conditions and/or symptoms, including prognosis.

List and describe any medications and/or prescribed aides (eyeglasses, hearing aides, mobility aides) used in the treatment of the condition(s).

Identify any limitations to performing the essential functions of the individual's job arising from the condition(s) stated above that remain even with the treatment listed previously. Also, indicate the severity and frequency of occurrence of the limitations. Be descriptive and specific because the information will help us better understand your patient's condition(s). Also, refer to the enclosed job description for information regarding the essential functions of the individual's position.

Additional comments, if any, may be included on this form or attached on an additional page.

Diagnosing Professional

Date

Signature

Professional's License Number

Mailing Address

Telephone Number

City, State, Zip

Fax Number