ABILITY TO WORK REPORT – VILAS COUNTY CHILD SUPPORT AGENCY

Patient Name: _____ Diagnosis: _____

Date of Birth: _____ Date of Injury/Illness: _____

Social Security Number: _____

_____

PLEASE SELECT **ONE** OF THE FOLLOWING OPTIONS:

1._____ Patient is PERMANENTLY & TOTALLY DISABLED as of _____(date)

OR

2._____Patient is TEMPORARILY, TOTALLY DISABLED as of _____(date)

Through _____(date) **AND**

a) On _____(date), patient will be reevaluated
   OR
b) Patient has been referred to _____ for further treatment/opinion.
   Name/Address/City/State/Phone: _____
   _____
   _____

OR

3._____Patient is PERMANENTLY, PARTIALLY DISABLED and has the following work restrictions as of _____(date), as follows/attached: _____
_____
_____

OR

4._____Patient is TEMPORARILY, PARTIALLY DISABLED and has the following work restrictions as of _____(date), as follows/attached: _____
_____
_____ **AND**
will be reevaluated on _____(date) **OR**
will be released to return to work without restrictions on _____(date).

Please return to:

Vilas County Child Support Office
330 Court Street
Eagle River, WI 54521
FAX: 715-479-3710

ABILITY TO WORK REPORT – VILAS COUNTY CHILD SUPPORT AGENCY

Patient Name:
Patient Social Security Number:
Patient Diagnosis:
Questions:

1. Is patient currently completely unable to work? If so, state the medical problem which causes the inability.

2. Is patient's ability to work limited? If so, state the medical problem which causes the limitations, and list the limitations (such as limited duties, hours, type of job).

3. Has the patient kept all scheduled appointments during the last six months? If not, please provide details.

4. Has the patient taken all prescribed medications during the last six months? If not, please provide details.

5. Has the patient followed all of your recommendations during the last six months? If not, list all recommendations which were not followed.

6. If the patient is able to work, with or without restrictions, state the date on which the patient became able to work.

7. If the patient is completely unable to work, and you know the date on which the patient will be able to resume working, state the date.

8. If the patient has a limited ability to work, and you know the date on which the patient will be able to resume working without limitations, state that date.

Medical provider's signature: _____
Medical provider's name (printed or typed): _____
Date : _____