
Attending Physician's Statement (APS)

The Policyholder is responsible for the completion of this form without expense to SLG Benefits

Patient (Last, First, Middle I.)	Date of Birth	Social Security #

Employee (Last, First, Middle I.)	Social Security #	Employer

I. HISTORY

Date of the accident ____ / ____ / ____ Date of symptom(s) onset ____ / ____ / ____

Date patient ceased work due to disability ____ / ____ / ____

Has patient ever had same or similar condition? Yes No If Yes, please explain in detail.

Is condition due to injury or sickness arising from patient's employment? Yes No Unknown

Please provide the names and addresses of any other treating physicians: (If more than one, please attach a separate sheet)

Have you ever treated patient prior to this illness? Yes No If yes, for what condition and when?

Is this condition due to an accident? Yes No If yes, please explain in detail.

II. DIAGNOSIS

Diagnosis (list Primary and all Secondary)

Subjective Symptoms

Objective Findings (including current EKG's, x-rays, laboratory data and any clinical findings)

III. DATES OF TREATMENT

Date of first visit ___ / ___ / ___ Date of last visit ___ / ___ / ___

Date last examination ___ / ___ / ___ Frequency of visits: Weekly Monthly Other (Specify)

IV. NATURE OF TREATMENT (Including Surgery and Medication prescribed, if any)

Current: Prospective:

V. PATIENT'S CONDITION

Patient has: Recovered Improved Relapsed Unchanged

If recovered, date able to return to work ___ / ___ / ___

Patient is: Ambulatory Hospital Confined Home Confined Bed Confined

Has patient been hospital confined? Yes No (If yes, please provide name and address of hospital, as well as confinement dates)

Confined from _____ to _____

Attending Physician Name (Please print)	Degree	Telephone Number
Address		
Physician Signature	Date	