

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

IMPORTANT: USE THIS FORM ONLY WHEN THE CLAIMANT BECOMES SICK OR DISABLED WHILE EMPLOYED OR BECOMES SICK OR DISABLED WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT. OTHERWISE USE GREEN CLAIM FORM DB-300.

PART B - DOCTORS STATEMENT (Please Print or Type)

The doctor's statement must be filled in completely. For item 7-d, give approximate date. Make some estimate. Delay in the payment of Disability Benefits may be prevented. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks."

1. Claimant's Name First Middle Last 2. Age

3. Male
 Female

4. Diagnosis/Analysis:

a. Claimant's Symptoms:

.....

b. Objective Findings:

5. Claimant Hospitalized? YES NO From To

6. Operation indicated? YES NO a. Type

7. Enter Dates for the following:

		Mo.	Day	Year
a. Date of your first treatment for this disability	b. Date			
b. Date of your most recent treatment for this disability				
c. Date Claimant was unable to work because of this disability.....				
d. Date Claimant will be able to perform usual work				

(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? YES NO

If yes, has Form C-4, C4C, or C-4P been filed with the Board? YES NO

Remarks (Attach additional sheet, if necessary)

9. I affirm that I am, a..... Licensed in the State of License No
(Physician, Podiatrist, Chiropractor, Dentist)

Doctor's Signature Date

Doctor's Name (Please Print) Tel. No.

Office Address
 Number Street City or Town State Zip Code