DISABILITY CERTIFICATE

Re: _____ _____

PATIENT NAME **DATE OF ACCIDENT**

I have examined and/or treated the above-named patient for injuries sustained in the aforementioned accident. As a result of the injuries received in this accident, ***I have disabled the patient from those activities that are marked with an "X" or the paragraphs with dates inputted:***

Diagnosis: _____

_____ (1) **Work/Employment Disability**: The patient has been on work disability from

_____ through _____.

_____ (2) **Work Restrictions**: The patient is restricted from lifting more than _____ lbs, and

also, cannot: _____

_____ (3) "**Housework" or replacement services**: As some housework may involve bending, lifting, twisting and prolonged standing, i.e. vacuuming, making beds, yard work, floors, carrying garbage or groceries, etc.. It is my opinion that the patient can not do housework and has been disabled from _____ to _____.

_____ (4) **Attendant Care**: The patient needed help taking care of his own personal needs including, but not limited to, dressing, bathing, using the restroom, supervising, driving to/from doctor appointments, carrying, passing medication, assisting with bathing, changing bandages, cleaning bandages, lifting, fetching, taking care of grooming needs, anything needing patient to bend or twist, feeding, and general hygiene needs. It is my opinion that the patient needed these services from _____ through

_____ for _____ hours a day, _____ days per week.

_____ (5) **Driving**: The patient is unable to drive and requires transportation services from

_____ to _____.

_____ (6) **Recreational Activities**: The patient should not engage or attempt to engage in activities that would aggravate his/her underlying condition by lifting greater than the amount indicated above, excessive bending, twisting, turning, or prolonged standing or sitting, i.e. running, climbing, biking, wrestling, etc..

Today's Date: _____ _____

Doctor's Signature

Print Name:_____