## In the Court of Common Pleas of Franklin County, Pennsylvania **Domestic Relations Section**



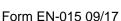
Member Name: **Docket Number: PACSES Case Number:** Other State ID Number:

Please note: All correspondence must include the PACSES Case Number.

## PHYSICIAN VERIFICATION FORM

TO BE COMPLETED BY THE TREATING PHYSICIAN: Physician's Name: Physician's License Number: Nature of patient's sickness or injury: Date of first treatment: (a) Date of most recent treatment: (b) Frequency of treatments: (c) (d) Medication: The patient has had a medical condition that affects his or her ability to earn income from: \_\_\_\_\_ through \_\_\_\_\_ If the patient is unable to work, when should the patient be able to return to work? Will there be limitations? REMARKS: Signed: \_\_\_\_ Signature of Treating Physician I authorize my physician to Physician's Address release the above information to the Franklin County Domestic **Relations Section.** Physician's Telephone Number





Date

Service Type

**Patient's Signature**