

In the Court of Common Pleas of Franklin County, Pennsylvania

Domestic Relations Section

Phone: (717) 264-6144

Fax: (717) 267-1223

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: _____

(a) Date of first treatment: _____

(b) Date of most recent treatment: _____

(c) Frequency of treatments: _____

(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: _____

Date: _____ Signed: _____

Signature of Treating Physician

**I authorize my physician to
release the above information to
the Franklin County Domestic
Relations Section.**

Physician's Address

Physician's Telephone Number

Patient's Signature

Date

Form EN-015 09/17

Service Type