In the Court of Common Pleas of County, Pennsylvania

Phone: **Fax:**

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

TO BE COMPLETED BY AN ADVANCED PRACTICE PROVIDER

Provider's Name: _____

Provider's License Number: _____

Provider's title (MD, DO, etc.) _____

Nature of patient's sickness or injury: _____

_____

_____

Date of first treatment: _____

Date of most recent treatment: _____

Frequency of treatments: _____

Medication: _____

_____

Due to the patient's medical condition, the patient can engage in the following types of work-related activity (mark all that apply):

__ Very heavy activity involving lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more, and the ability to perform heavy, medium, light, and sedentary activity.

__ Heavy activity involving lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds, and the ability to perform medium, light, and sedentary activity.

__ Medium activity involving lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds, and the ability to perform light and sedentary activity.

___ Light activity involving lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds, a good deal of walking or standing, or sitting with some pushing and pulling of arm or leg controls.

__ Sedentary activity involving lifting no more than 10 pounds at a time, occasionally lifting or carrying articles like docket files, ledgers, and small tools, sitting, and occasionally walking and standing.

__ None. Based on my assessment, I found that the patient's condition is such that he or she cannot engage in any type of work-related activity.

Please mark whether the patient's condition is ___ temporary or ___ permanent.

If the patient cannot engage in any type of work-related activity and the patient's condition is temporary, when should the patient be able to engage in any type of work-related activity _____

Will there be limitations?_____

_____

Additional Remarks: _____

_____

Signature of Treating Provider: _____ Date: _____

Provider's address: _____

_____

_____

Provider's telephone number: _____

I authorize my provider to release the above information to the _____ County Domestic Relations Section.

Patient's signature: _____ Date: _____