BOARD OF COUNTY COMMISSIONERS

CLERMONT COUNTY, OHIO

To:

RE: Disability Statement Concerning: _____ DOB_____

The undersigned physician is licensed in the State of _____ and has treated the patient referenced above for [DESCRIBE DIAGNOSES AND/OR MEDICAL CONDITION(S) FOR WHICH YOU ARE TREATING THIS PATIENT AND/OR THOSE REFLECTED IN HIS/HER MEDICAL RECORDS AVAILABLE TO YOU AS A TREATING PHYSICIAN]:

_____

_____

_____

PLEASE CHECK ONLY ONE BLOCK AND COMPLETE REQUESTED INFORMATION.

1. UNABLE TO WORK BASED ON CURRENT DOCTOR/PATIENT INTERACTION:

☐ To a reasonable degree of medical certainty I am of the opinion that the patient was unable to work from _____ to _____ as a result of the condition(s)/diagnoses listed above. Patient will be able to return to work on _____.

2. UNABLE TO WORK OPINION BASED ON REVIEW OF MEDICAL RECORDS:

☐ To a reasonable degree of medical certainty, following a review of the patient's medical records, I am of the opinion that the patient was unable to work from _____ to _____ due to the condition(s)/diagnoses in his/her records, which I have set out above. Patient will be able to return to work on _____.

3. ABLE TO WORK OPINION

☐ It is my opinion to a reasonable degree of medical certainty that the patient is NOT PREVENTED FROM WORKING due to the condition(s)/diagnoses listed above.

/_____ DATE:_____

Physician's Signature

Printed Name of Physician:_____

Address:_____

City/State/Zip:_____

PLEASE FAX TO: (513) 732-7444.

DEPARTMENT OF JOB AND FAMILY SERVICES
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