DEPARTMENT OF JOB AND FAMILY SERVICES
CHILD SUPPORT ENFORCEMENT
2400 Clermont Center Drive, Suite 107
Batavia, Ohio 45103
Telephone: (513) 732-7248 Fax: (513) 732-7444

TO: Review and Adjustment Coordinator
Child Support Enforcement

RE: Disability Statement Concerning: ______________________________ (Patient name)

Date of birth: ____________________ Social Security No.: ____________________

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]:

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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.

/S/ ________________________________ DATE: ______________________________
Physician's Signature
Printed name of physician: ____

Address: ____

City/State/Zip: ____

PLEASE FAX TO (513) 732-7444.

Website form 130911