PACIFIC GUARDIAN LIFE

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PART C - DOCTOR'S STATEMENT

IMPORTANT: Please complete and mail within 7 working days after examination to the insurance carrier listed above unless otherwise directed in Part A (23) or Part B (13)

1. Claimant's Name (First, Middle, Last)	2. Age	3. Sex ❑ Male ❑ Female

4. Physical requirements of claimant's occupation as related by claimant

5. Diagnosis

6. If pregnancy, advise expected date of birth ________________ ❑ Normal Delivery ❑ C-Section

If disability is pregnancy with complications, advise complications:

____

7. Was claimant's disability caused by claimant's employment? ❑ Yes ❑ No ❑ Unknown

Was a Physician's Report WC-1 filed? ❑ Yes ❑ No If yes, filed with ________________

8. Was claimant hospitalized? ❑ Yes ❑ No From: ________ (month/day/year) through ________ (month/day/year)

Surgery Indicated? ❑ Yes ❑ No Type ________________ Scheduled date of surgery ________ (month/day/year)

9. Complete the following:	Month	Day	Year
Date of your first treatment of this disability			
First date claimant unable to perform the duties of employment (see #4 above)			
Date of your most recent treatment of this disability			
Date claimant will be able to perform usual work (estimate) (DO NOT use "undetermined" or "unknown")			

10. Are you referring the claimant to another physician? ❑ Yes ❑ No If yes, give name ________________

or

Was claimant referred to you? ❑ Yes ❑ No If yes, give name ________________

I hereby certify that the above information is true and complete to the best of my knowledge.

Doctor's Name (Please Print)	Degree/Specialty	Office Address	Email Address

Doctor's Signature	Date	Telephone No.	Fax No.