PHYSICIAN'S FORM REGARDING DISABILITY

FOC Client Name:_____ **Docket #:** _____

I,_____, hereby authorize my treating/examining health care provider to release the information contained in this form and/or applicable medical and/or psychological information to the 13th Circuit Court, Family Division and Friend of the Court.

_____ _____

Patient Signature Date:

<u>This portion to be completed and signed by the treating physician or other health care provider:</u>

Friend of the Court, 13th Circuit and Family Court, 328 Washington St Ste 200, Traverse City MI 49684
Telephone: 231-922-4660 Fax: 231-922-4575 Email: Friendofthecourt@13thcircuitcourt.org

The above-named client has represented that he/she has a condition that restricts or prevents his/her ability to work. The following information is needed from his/her treating physician(s):

Diagnosis:

Treatment plan:

Anticipated length of treatment and anticipated recovery date:

Date of next appointment:

Can this individual work in any capacity at this time? (Circle one) Yes No

If no, what is the expected date of return to work? _____

Please check one of the following:

☐ 60 days ☐ 120 days ☐ 180+ days

Can this individual work with restrictions? (Circle one) Yes No
Please state the restrictions:

Check all that apply: ☐ Part-time only hours ☐ No lifting ☐ Limited standing ☐ Other _____

_____ _____

Physician Name Physician Signature

_____ _____

Address Date

_____ _____

Address Telephone number

Thank you for your time and cooperation in completing this form