IN THE COURT OF COMMON PLEAS OF _____ COUNTY

Member Name:

Docket Number:

PACSES Case Number:

Other State ID Number:

PHYSICIAN VERIFICATION FORM

TO BE COMPLETED BY THE TREATING PHYSICIAN

Physician's name: _____

Physician's license number _____

Nature of patient's sickness or injury:

_____

_____

_____

_____

Date of first treatment:_____

Date of most recent treatment:_____

Frequency of treatments:_____

Medication:_____

The patient has had a medical condition that affects his or her ability to earn income from: _____ through _____

If the patient is unable to work, when should the patient be able to return to work?

Will there be limitations? _____

_____

Remarks: _____

_____

Date: _____

Signature of Treating Physician: _____

Physician's address: _____

_____

_____

Physician's telephone number: _____

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

Patient's signature: _____ Date: _____