CMS ILLINOIS DEPARTMENT OF
CENTRAL MANAGEMENT SERVICES

PHYSICIAN'S STATEMENT

AUTHORIZATION FOR DISABILITY LEAVE AND RETURN TO WORK

Name of Patient (full): _____ Date of Birth: _____ Soc. Sec. Number: _____

Present Address—Street or Rural Route: _____

City: _____ State: _____ Zip Code: _____

Employed by State of Illinois: _____
(Agency, Board, Commission, Department)

Facility: _____ Address: _____

COMPREHENSIVE MEDICAL INFORMATION IS REQUIRED IN ORDER TO EVALUATE THE EMPLOYEE'S CLAIM FOR A DISABILITY LEAVE OF ABSENCE OR SUBSEQUENT RETURN TO WORK

1. DIAGNOSIS (including any complications):

(a) Date of last examination: Month: _____ Day: _____ 20 _____

(b) Diagnosis including any complications: _____

_____

_____

_____

(c) Subjective symptoms: _____

_____

_____

_____

(d) Objective findings (including information derived from x-rays, EKG's, laboratory data and any clinical findings): _____

_____

_____

_____

2. DATES OF TREATMENT:

(a) Date of first visit: Month _____ Day: _____ 20 _____

(b) Date of last visit: Month _____ Day: _____ 20 _____

(c) Frequency: ☐ Weekly ☐ Monthly ☐ Other—(Please specify) _____

_____

3. TREATMENT:

(a) Please describe any surgery and / or , medication prescribed: _____

_____

(b) Will treatment substantially improve function and employability? ☐ Yes ☐ No If yes specify: _____

_____

IMPORTANT NOTICE

This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under 20 ILCS 415/8c(2). Disclosure of this information is **VOLUNTARY**. This form has been approved by the State Forms Management Center.

4. PROGRESS: (Please check appropriate box provided below):

(a) The patient has: ☐ Recovered ☐ Improved ☐ Remained Unchanged ☐ Retrogressed

(b) The patient is: ☐ Ambulatory ☐ House Confined ☐ Bed Confined

(c) Has the patient been hospital confined because of current condition? ☐ Yes ☐ No

If yes, give name and address of hospital: _____

_____

Confined from: Month Day 20 Through Month Day 20

5. LIMITATION: (If there is a limitation, check appropriate box and describe below):

☐ Standing ☐ Climbing ☐ Bending ☐ Use of Hands ☐ Stooping
☐ Lifting ☐ Psychological ☐ Other (Please specify):

6. PHYSICAL IMPAIRMENT: (*As defined in Federal Dictionary of Occupational Titles):

☐ Class 1 –No limitation of functional capacity; capable of heavy work * No restrictions(0-10%)
☐ Class 2 -- Medium manual activity * (15%-30%)
☐ Class 3 – Slight limitation of functional capacity; capable of light work* (35%-55%)
☐ Class 4 – Moderate limitation of functional capacity; capable of clerical / administrative (sedentary*) activity (60%-70%)
☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75%-100%)
☐ Remarks--

7. EXTENT OF DISABILITY:

		From Any Occupation			***From Patient's Regular Occupation***		
(a)	In your opinion is patient now temporarily totally disabled?	☐ Yes		☐ No	☐ Yes		☐ No
		Month	Day	Year	Month	Day	Year
(b)	If no, when was patient able to go to work?			20			20
		Month	Day	Year	Month	Day	Year
(c)	If yes, what is the approximate date patient will be able to resume work?			20			20
(d)	In your opinion is patient permanently and totally disabled for employment?	☐ Yes		☐ No	☐ Yes		☐ No

(e) If answer to (d) is yes, please explain.

_____

_____

8. REMARKS:

Attending Physician Signature: _____ Degree: _____ Date _____

PLEASE TYPE OR PRINT THE FOLLOWING INFORMATION:

Attending Physician's Name: _____

Physician's Office Street Address:

City: State: Zip Code: Phone Number:

TO EMPLOYEES: You are responsible for having this form completed and returned to the appropriate person within your agency Within the time limits established by your agency. Your failure to comply may result in termination of your disability leave.