TDI–3P (7-1-12)

RHODE ISLAND DEPARTMENT OF LABOR AND TRAINING
TEMPORARY DISABILITY INSURANCE DIVISION
PO BOX 20100 CRANSTON, RHODE ISLAND 02920-0941
Tel.# for Physician offices only: (401) 462-8447 Tel.# for patients: 401-462-8420 FAX # (401) 462-8466

STATEMENT OF QUALIFIED HEALTHCARE PROVIDER (QHP)

(Physician or Medical Practitioner)

Printed from Website

Treating Physician or Medical Practitioner's Name:
_____

Treating Physician or Medical Practitioner's Address:
_____
_____
_____

Claimant's S.S. #: _____-_____-_____
Claimant's Name: _____
Customer's Address:

Customer's Phone #:_____
Email Address:_____
Date of Birth: _____/_____/_____

BELOW THIS LINE MUST BE COMPLED BY A PHYSICIAN OR MEDICAL PRACTITIONER ONLY

If the above claimant is <u>able to perform their regular and customary work</u> while being treated for the current illness/injury and he/she does not have a job to return to, please indicate a recovery date. He/She may be eligible for Unemployment Insurance benefits.

1. Diagnosis (not symptoms):_____ **ICD9-CM Code _____(Required)**
2. What are the functional limitations, if any, preventing him/her from performing customary work duties?
   _____
3. Cause of illness/injury: ☐ Work related ☐ Illness ☐ Pregnancy ☐ Auto accident ☐ Other:_____
   If work related, please indicate the <u>name of the insurance carrier</u> being billed. _____
4. Any Complications slowing recovery**:**_____
5. **Provide date from which you are certifying he/she as <u>functionally</u> "unable to work".** _____/_____/_____
   <u>NOTE:</u> this date must occur <u>the week prior to</u>, <u>the week of</u>, or <u>the week following</u> your physical examination of the claimant. (Diagnoses via telephone calls are not permitted by TDI law.)
6. Certifying examination date for current illness: ____/____/___ Most recent examination date for current illness:___/___/___
7. Was patient hospitalized for this illness/injury? ☐ yes ☐ no
   Hospital name: _____ Date Admitted:_____/_____/_____Date Discharged: ____/_____/_____
   Did patient have surgery? ☐ yes ☐ no
   If yes, what type of surgery:_____ Date of surgery: ____/_____/_____
8. If Pregnancy, expected delivery date: ____/_____/_____ Actual delivery date: ____/_____/_____
   Type of delivery: ☐ Vaginal ☐ C-section
   Please provide any pregnancy complications; <u>Pre</u> ☐ or <u>Post</u> ☐ partum:_____
9. Is patient able to work pending surgery or delivery? ☐ Full time work ☐ Part time work ☐ No work
10. Based on the information provided, it is your medical opinion that, the above mentioned patient will be:

UNABLE TO WORK AS OF THIS DATE:(see #5) ___/___/___ **FOR THIS NUMBER OF WEEK(S)**:_____(How many weeks)

11. Is patient able to return to customary work on a full time basis? ☐ yes ☐ no If yes, as of what date: ____/_____/_____
12. Is patient able to return to less then his/her normal hour of work? ☐ yes ☐ no
    If yes, as of what date and for how many hours per day & week? Date: ___/___/____**Hours per day:_____ Hours per week:_____**
    For how many **<u>weeks</u>** is patient able to work less than his/her normal hours?_____(Weeks).

Having considered the patient's regular and customary work, I certify under penalty of perjury that, based on my in-office examination, this medical certification truly describes the patient's disability (if any) and the estimated duration thereof. I also understand that if I make a false statement or fail to disclose facts, with intent to defraud the TDI Program, I shall upon conviction be punished to the full extent allowed by law including fine and /or imprisonment.

I further certify that I am a _____-_____License #:_____
(Type of Qualified Healthcare Provider-QHP) (Specialty)
QHP's Name:_____ Phone #:_____Fax#:_____
Signature:_____ **Date**:_____

Please note: TDI is not responsible for costs incurred for copying medical records or completing medical forms. Any costs incurred is the responsibility of the claimant. **<u>Please mail to above address or fax to: (401) 462-8466</u>**