FORM APPROVED
OMB NO. 0960-0511

DISABILITY UPDATE REPORT

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a) and 1631(e)(1)(A) and (B) of the Social Security Act, as amended, and Social Security regulations at 20 C.F.R. 404.1589 and 416.989 authorize us to collect this information. We will use the information you provide to further document your claim and permit a determination about continuing disability.

The information you furnish on this report is voluntary. However, failure to provide us with the requested information could prevent us from making an accurate and timely decision on your claim.

We rarely use this information you supply for any purpose other than for reviewing your claim for Social Security benefits. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information are available in our Systems of Records Notices entitled, Claims Folders Systems (60-0089) and the Master Beneficiary Record (60-0090). These notices, additional information regarding this form, routine uses of information, and our programs and systems are available on-line at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. The OMB control number for this collection is 0960-0511. We estimate that it will take 15 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

Name and Address | Claim Number

1. Within the last 2 years have you worked for someone or been self-employed?

Yes _____ No _____

If yes, please complete the information below.

	Work Began (month/year)	Work Ended (month/year)	Monthly Earnings
1.	____/____	____/____	$ _____
2.	____/____	____/____	$ _____
3.	____/____	____/____	$ _____

2. Check the block which best describes your health within the last 2 years:

Better _____ Same _____ Worse _____

3. Within the last 2 years has your doctor told you that you can return to work?

Yes _____ No _____

4. Within the last 2 years have you attended any school or work training program(s)?

Yes _____ No _____

5. Would you be interested in receiving rehabilitation or other services that could help you get back to work? Yes _____ No _____

6. Within the last 2 years have you been hospitalized or had any surgery?

Yes _____ No _____

If yes, please list below:

Reason	**Date: (month/year)**
1. _____	_____
2. _____	_____
3. _____	_____

7. Within the last 2 years have you gone to a doctor or clinic for your condition?

Yes _____ No _____

If yes, show the date and the reason for the visit.

1. Date _____

   Reason _____

2. Date _____

   Reason _____

3. Date _____

   Reason _____

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Sign Here ▶ Date Telephone Number