**RAILROAD RETIREMENT BOARD MEDICAL ASSESSMENT OF PHYSICAL**

**RESIDUAL FUNCTIONAL CAPACITY**

**RE: Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SS#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*PLEASE DESCRIBE BELOW any restrictions in the claimant’s ability to perform basic work-related functions within a regular work setting on a day-to-day basis. Please relate any assessed reduction to capacity to particular medical findings. Please do not consider non-medical factors such as age, sex, education, or work experience.*

I.A.1. Frequency and length of contact**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Prognosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. List your patient’s *symptoms*, including pain, dizziness, fatigue, etc.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Identify clinical findings and objective signs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. If your patient has pain, characterize the nature, location, frequency, precipitating factors, and severity, of your patient’s pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Describe the treatment and response including any side effects of medication that may have implications for any potential for working, e.g., drowsiness, dizziness, nausea, etc.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Have your patient’s impairments lasted or can they be expected to last 12 months? \_\_\_\_ yes \_\_\_ no

II.A.1. EXERTIONAL RESTRICTIONS – For the claimant’s Physical Impairments:

In an 8-hour workday the claimant can STAND and/or Walk, with normal breaks for (check appropriate line):

\_\_\_\_ Less than 2 hours total \_\_\_\_ at least 2 hours total \_\_\_\_ 6 hours or more

MEDICAL FINDINGS TO SUPPORT RESTRICTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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2.

In an 8-hour workday the claimant can SIT, with normal breaks for (check appropriate line):

\_\_\_\_ Less than 6 hours total \_\_\_\_ 6 hours or more

MEDICAL FINDINGS TO SUPPORT RESTRICTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*Regarding the questions contained within this form “****Rarel****y” means 1% to 5%: “****Occasionall****y” means 6% to*

*33%; “****Frequentl****y” means 34% to 66%: “****Unlimited****” means 67% or more of an 8-hour working day.*

3. a. How many pounds can your patient **lift** and **carry** in a **competitive** work situation?

**Never Rarely**  **Occasionally Unlimited**

Less than 10 lbs. \_\_ \_\_ \_\_ \_\_

10 lbs. \_\_ \_\_ \_\_ \_\_

20 lbs. \_\_ \_\_ \_\_ \_\_

50 lbs. \_\_ \_\_ \_\_ \_\_

MEDICAL FINDINGS TO SUPPORT RESTRICTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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4. How often can your patient perform the following activities?

**Never Occasionally Frequently**

Twist \_\_ \_\_ \_\_

Bend/Stoop \_\_ \_\_ \_\_

Crouch/squat \_\_ \_\_ \_\_

Climb ladders \_\_ \_\_ \_\_

Climb stairs \_\_ \_\_ \_\_

Kneel \_\_ \_\_ \_\_

Crawl \_\_ \_\_ \_\_

Balance \_\_ \_\_ \_\_

MEDICAL FINDINGS TO SUPPORT RESTRICTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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5. Yes or no, can the Patient use BOTH HANDS for **repetitive**:

Simple Grasping: \_\_\_ yes \_\_\_no, Fine Manipulation: \_\_\_ yes \_\_\_no, Pushing/Pulling: \_\_\_ yes \_\_\_no.

MEDICAL FINDINGS TO SUPPORT RESTRICTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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6. Yes or no, can the Patient use BOTH FEET for repetitive foot controls? \_\_\_ yes \_\_\_no

7. Yes or no, can the Patient without restriction: Hear \_\_\_ yes \_\_\_no, Speak \_\_\_ yes \_\_\_no, See \_\_\_ yes \_\_\_no

MEDICAL FINDINGS TO SUPPORT RESTRICTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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B. **Environmental Restrictions** – For all claimants as applicable and r*egarding the questions contained within this form “****Mildly”*** *means the patient’s tolerance/ability to function is limited but satisfactory: “****Moderately****” means tolerance/ability to function is seriously limited, but not precluded.*

Patient is restricted in activities involving:

**No Mildly** **Moderately Totally**

Unprotected Heights \_\_ \_\_ \_\_ \_\_

Driving/Operating Machinery \_\_ \_\_ \_\_ \_\_

Being Around Moving Machinery \_\_ \_\_ \_\_ \_\_

Uneven Terrain/Stairs \_\_ \_\_ \_\_ \_\_

Exposure to Dust, Fumes, Etc. \_\_ \_\_ \_\_ \_\_

Exposure to Noise \_\_ \_\_ \_\_ \_\_

Exposure to Vibration \_\_ \_\_ \_\_ \_\_

Exposure to Temperature Extremes \_\_ \_\_ \_\_ \_\_

Exposure to Extremes in Humidity \_\_ \_\_ \_\_ \_\_

MEDICAL FINDINGS TO SUPPORT RESTRICTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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C. **Mental Restrictions** – For all patients with mental impairments, if any, do emotional factors contribute to severity of patient’s the symptoms or functional limitations? \_\_\_\_ yes \_\_\_\_ no

Claimant is limited in ability to:

**No Mildly** **Moderately Totally**

Reason, Use Judgment \_\_ \_\_ \_\_ \_\_

Maintain Appropriate Mood \_\_ \_\_ \_\_ \_\_

Maintain Personal Habits \_\_ \_\_ \_\_ \_\_

Perform Normal Daily Activities \_\_ \_\_ \_\_ \_\_

Make Social Adjustments \_\_ \_\_ \_\_ \_\_

Relate to Other People \_\_ \_\_ \_\_ \_\_

Make Occupational Adjustments \_\_ \_\_ \_\_ \_\_

Maintain Normal Work Pace \_\_ \_\_ \_\_ \_\_

Maintain Normal Concentration \_\_ \_\_ \_\_ \_\_

Relate Appropriately with co-workers \_\_ \_\_ \_\_ \_\_

Relate Appropriately with the  \_\_ \_\_ \_\_ \_\_

General Public

Relate Appropriately with Supervisors \_\_ \_\_ \_\_ \_\_

Remember/Understand/Carry Out \_\_ \_\_ \_\_ \_\_

Instructions

MEDICAL FINDINGS TO SUPPORT RESTRICTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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D. **Additional Relevant Restrictions** – For all patients with impairments, especially with neck problems, how often can the individual perform the following *Physical Functions and activities*?

**Never Occasionally Frequently**

Hold Head in Static Position \_\_ \_\_ \_\_

Look UP \_\_ \_\_ \_\_

Look Down \_\_ \_\_ \_\_

Turn head fully to right or left \_\_ \_\_ \_\_

Reach Above Chest Level \_\_ \_\_ \_\_

Reach, Push, Pull Above Shoulders \_\_ \_\_ \_\_

MEDICAL FINDINGS TO SUPPORT RESTRICTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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E. If placed in an employment situation will the patient require job that permits shifting positions at *will* ? \_\_\_\_ yes \_\_\_\_ no

F. Will patient need **unscheduled breaks** in an 8-hour work day? \_\_\_\_ yes \_\_\_\_ no

If Yes, please answer 1) & 2) below.

1) How *often* do you think this will happen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) What is the average length of time the patient will have to **rest** and be off task before returning to work? \_\_\_\_\_\_\_\_\_ **Minutes**  \_\_\_\_\_\_\_\_\_\_ **Hours**

G. With prolonged sitting, will patient need one or both leg(s) **elevated** at/above waist level? \_\_\_\_ yes \_\_\_\_ no If the answer is yes,

1) What ***percentage of time***during an 8-hour working day should the patient’s leg(s) be elevated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**%**

2) Will the patient use a cane or other assistive device? \_\_\_\_ yes \_\_\_\_ no

H. To what degree can patient tolerate work stress (i.e., maintain persistence and pace required within the confines of competitive work)? \_\_\_ Incapable of “low stress” \_\_\_ Capable of “low stress” \_\_\_ Moderate stress \_\_\_ High stress work

I. Are your patient’s impairments (physical impairments plus any emotional impairments) *reasonably consistent* with the symptoms and functional limitations described in the evaluation? \_\_\_\_ yes \_\_\_\_ no

J. How frequently during a typical workday how would you reasonably anticipate that your patient’s experience

of pain or other symptoms including the effects or side effects of medications would be severe enough to interfere with **attention and concentration** needed to perform even simple repetitive tasks?

\_\_\_ **Never** \_\_\_ **Rarely** \_\_\_ **Occasionally** \_\_\_ **Frequently** \_\_\_ **Constantly**

K. Will patient’s condition produce “good days” and “bad days”? \_\_\_\_ yes \_\_\_\_ no

If yes, please estimate, on the average, how many days per month your patient is likely to be absent from work as a result of the impairments or need for treatment.

\_\_ **never** \_\_ **about 1 day/mo.** \_\_ **about 2 days/mo.** \_\_ **about 3 days/mo.** \_\_ **about 4 days/mo.** \_\_ **more than 4 days/mo.**

L. Please describe any other limitations that would affect your patient’s ability to work at a regular job on a sustained basis:

PLEASE INCLUDE ANY MEDICAL FINDINGS TO SUPPORT ANY FURTHER RESTRICTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

M. **What is the earliest date the symptoms and limitations described above in this questionnaire apply? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Date of Earliest Application of symptoms)**

**Physician’s Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date** **Completed**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed/Typed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Or Please Attach Physician’s Business Card hereunder. Physician must be an M.D., D.O., DPM,**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Return from to:

Mike Murburg, P.A.  
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Tampa, FL 33613

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