

**FROC, P.C.**  
**Disability Forms:**  
**Instructions:**

updated 6/7/2016

- **Please Allow 10 to 14 days to Complete**

Is this an update to an existing claim? **YES** or **NO**

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Occupation and duties:

\_\_\_\_\_

What duties of your job does your condition prevent you from performing?

\_\_\_\_\_

\_\_\_\_\_

**Is this a continuous leave: YES NO**

Start date of disability (date you stopped/will stop work): \_\_\_\_\_

Estimated date you plan to return to work: \_\_\_\_\_

Do you plan on returning to part-time or restricted work (prior to full-time, full release work): **YES** or **NO**, If yes,

Estimated Date: \_\_\_\_\_, in what capacity? \_\_\_\_\_

**Do you plan on intermittent leave? YES NO**

Dates of intermittent leave: \_\_\_\_\_

What would you like for us to do with your completed form(s)?

**Pick Up at Office: YES** or **NO** If no:

**Mail to, address:** \_\_\_\_\_

\_\_\_\_\_

**Fax to:** \_\_\_\_\_

\_\_\_\_\_

**Official Use Only:**

**Dr.:** \_\_\_\_\_ **Acct#:** \_\_\_\_\_

**Type:** \_\_\_\_\_

**Rec'd: Date:** \_\_\_\_\_ **Initials:** \_\_\_\_\_