ATTENDING PHYSICIAN'S STATEMENT

State Form 45547 (R8 / 9 - 24)

STATE OF INDIANA
State Personnel Department
Benefits Division, Disability Program

This form Is confidential per IC 5-14-3-4(A) (9).

Mail completed form to:

JWF Specialty CO., Inc (Third Party Administrator)
PO Box 40968
Indianapolis, IN 46240-0968
Telephone: (888) 818-7795
Fax: (866) 893-4674

This form is to be completed without expense to the State of Indiana

THIS SECTION IS TO BE COMPLETED BY EMPLOYEE / PATIENT (Please print.)

Name of patient	Date of birth (month, day, year)
Name of agency	
Job title	Gender ☐ Male ☐ Female

THIS SECTION IS TO BE COMPLETED BY PHYSICIAN

I. HISTORY

a) When did symptoms first appear or accident happen?

b) Has the patient ever had the same or similar condition? ☐ Yes ☐ No ☐ Unknown

If yes, state when and describe.

c) Name(s) and address(es) of other treating physician(s)

Is the condition due to injury or sickness arising from patient's employment? ☐ Yes ☐ No ☐ Unknown

II. DIAGNOSIS

a) Diagnosis (including any complications)

b) CPT code	c) If pregnancy, estimated date of delivery

d) Subjective symptoms

e) Objective findings (including current x-rays, EKGs, laboratory data ad clinical findings)

III. TREATMENT

a) Date of first visit (month, day, year)	b) Date of last visit (month, day, year)

c) Frequency of treatment:

☐ Weekly ☐ Monthly ☐ Other (Specify)

d) Date(s) of treatment for condition

e) Nature of treatment (including surgery and medication prescribed, if any)

f) Has the patient been hospital confined? ☐ Yes ☐ No	g) If yes, dates confined from / through (month, day, year)
h) Name and address of hospital	

IV. PYSICAL 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 (dentary) activity * 60 – 70%)
☐ Class 5 – Severe limitation of functional capacity; incapable of minimum (sedentary) activity * (75 – 100%)
Other limitations:

V. MENTAL / NERVOUS IMPAIRMENT (If applicable.)

a) Please define "stress" as it applies to this claimant

b) What stress and problems in interpersonal relations has claimant had on job?

☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations)
☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
☐ Class 3 – Patient is able to engage in only limited stress situations and engage in limited interpersonal relations (moderate limitations)
☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations) Other limitations:

VI. WORK STATUS

a) Date patient became totally disabled from this condition (month, day, year)	b) Anticipated return to work date?

VII. REMARKS

(Limitations, therapy, etc.)

I declare that I have examined this report, and the statement contained herein is the best of my knowledge and belief true, correct, and complete. I further understand that a fraudulent misstatement in completing this form would result in a loss of benefits for my patient. *Do not provide any genetic information when responding to this request.*

Signature of attending physician	Date
Printed name	Degree
Telephone number	Fax number
Address (number and street, city, state, and ZIP code)	