

Disability Benefits Medical Assessment Form Sample

The **Disability benefits medical assessment form sample** provides a clear template for evaluating an individual's medical condition. This form assists healthcare professionals in documenting relevant health information to support disability claims. Accurate completion ensures timely and fair processing of benefits.

Personal Information

Full Name:

Date of Birth:

Address:

Phone:

Medical Information

Primary Diagnosis:

Secondary Conditions (if any):

Onset Date of Condition:

Functional Limitations

Physical Limitations:

Mental/Cognitive Limitations:

Treatment Details

Current Treatment:

Medications:

Referrals to Specialists:

Physician's Details

Physician Name:

Medical License Number:

Clinic Address:

Certification

☐ I certify that the above information is accurate to the best of my knowledge.

Date:

Physician's Signature:

Submit