Neurology Specialists

Disability/Work Capacity Form

Name:_____Date:_____

Date Symptoms Began:_____

Date Diagnosis Made: _____

Date Disability Began: _____

Diagnosis for Disability: _____

_____

Last Day Worked: _____

If working part–time, date begun: _____
(Hours/Days, or Days/Week)

Current work restrictions: _____

_____

_____

_____

Employer/Job title: _____

If you are not currently working, who certified work disability? _____

_____ When? _____

Short Term: _____ Long Term: _____

Why are you disabled?_____
(What can you not do?)

_____

_____

_____

Patient Name_____

What aspects of your job can you not perform?_____

List cognitive/memory problems: _____

Extra:_____

Signature_____