Verification of Permanent/Chronic Disability (Supplementary Information Requested)

NOTE: Forms completed or altered by anyone other than the Certifying Medical Professional whose signature appears on this form will not be processed.

Patient Information	
Legal Name:	Date of Birth (MM/DD/YYYY):

Please check one: I certify that I am a ☐ **Medical Doctor** with expertise in diagnosing and/or treating the condition(s) indicated below.

1. Indicate your **formal diagnosis/diagnoses**:

Formal Diagnosis	ICD Diagnostic Code	Date of Onset	Expected to Persist ☑
			☐ Less than 2 years ☐ 2+ years ☐ Not expected to improve
			☐ Less than 2 years ☐ 2+ years ☐ Not expected to improve
			☐ Less than 2 years ☐ 2 + years ☐ Not expected to improve

2. List the major symptoms of the medical condition that **currently affect the Patient** (be sure to include any significantly impairing side effects from medication that affect the Patient; attach an additional sheet if required):

Symptom	Persists with Treatment ☑	Frequency			
		Daily	Weekly	Monthly	Other (Specify)
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

3. This condition affects:

☐ The whole person

or

☐ A specific system, body part, or organ (specify):

4. Indicate on each scale the number that best represents the Patient's **current level of functioning**, *even with treatment*, for the activities of daily living listed below:

School/Work/Life Activity	**No Limitation → Totally Impaired**	**Unknown/Not Assessed ☑**
Walking indoors	1----------2----------3----------4----------5	☐
Walking outdoors	1----------2----------3----------4----------5	☐
Standing	1----------2----------3----------4----------5	☐
Sitting	1----------2----------3----------4----------5	☐
Performing manual tasks	1----------2----------3----------4----------5	☐
Performing mental tasks	1----------2----------3----------4----------5	☐
Carrying and holding	1----------2----------3----------4----------5	☐
Living alone	1----------2----------3----------4----------5	☐
Sleeping	1----------2----------3----------4----------5	☐
Eating	1----------2----------3----------4----------5	☐
Interacting socially	1----------2----------3----------4----------5	☐
Managing self care	1----------2----------3----------4----------5	☐
Attending classes regularly	1----------2----------3----------4----------5	☐
Handwriting	1----------2----------3----------4----------5	☐
Keyboarding	1----------2----------3----------4----------5	☐
Speaking	1----------2----------3----------4----------5	☐
Breathing	1----------2----------3----------4----------5	☐
Other: _____ _____	1----------2----------3----------4----------5	
Other: _____ _____	1----------2----------3----------4----------5	
Other: _____ _____	1----------2----------3----------4----------5	
Other: _____ _____	1----------2----------3----------4----------5	

5. Indicate the following:

   a. Date the Patient was first seen by you: _____

   b. How frequently you have treated the Patient **in the past 2 years**[1] (choose only one):

   ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other: _____

6. Is there **anything else** you think we should know about the Patient's medical condition?

Certifying Medical Professional

*I certify that the information provided on this form is **accurate** to my knowledge and the Patient identified in this assessment **experiences the impairments** I have indicated.*

Name of Certifying Medical Assessor:		Registration/Certificate#
Specialty/Occupation of Medical Assessor:		Telephone Number:
Mailing Address:		Fax Number:
City/Town:	Province:	Postal Code:
Signature (in ink):		Date:

[1] **Note to Applicant:** A short case history with your doctor may require additional medical documentation from your current and/or previous doctor.