



Benefits
 Department of Human Resources
 Division of Administrative & Business Services
 University of Cincinnati
 PO Box 210099
 Cincinnati, Ohio 45221-0099
 Phone: 513-556-6381
 Fax: 513-556-4501

**UNIVERSITY OF CINCINNATI
 ATTENDING PHYSICIAN'S STATEMENT
 FOR HANDICAPPED CHILDREN**

This report requests evidence of the Handicapped Child Status of your patient, to assist us in determining eligibility for group coverage beyond the dependent age limit. "Handicapped Child Status" is generally defined as the incapacity to achieve self-support through employment at a minimum level because of any condition defined by contract or law as a handicap.

Please include sufficient details of history, physical and diagnostic findings, clinical course, therapy and response, and vocational plans to enable us to make a determination of the patient's incapacity.

The completed form should be returned to the Benefits Office at the above address.

THIS SECTION IS TO BE COMPLETED BY EMPLOYEE

Patient's Name _____ Date of Birth _____

Employee's Name _____ Employee's SSN _____

1. HISTORY

(a) Patient's Age _____

(b) When did symptoms first appear or accident happen? _____

(c) Date patient became incapacitated by handicap?* _____

(d) Has patient been continuously incapacitated? Yes No

If no, explain _____

(e) Is patient totally disabled? Yes No

If no, explain _____

*Incapable of self-sustaining employment

2. DIAGNOSIS (Nature of handicap, including complications)

(a) Subjective symptoms _____

(b) Objective findings (including current signs, laboratory data & X-ray results, EKG, pulmonary function studies, etc.) _____

3. DATES OF TREATMENT

(a) Date of first visit _____

(b) Date of last visit _____

(c) Frequency Weekly Monthly Other (Specify) _____

4. NATURE OF TREATMENT (Including educational training, surgery, therapy and medications, etc.) _____

5. PROGRESS

(a) Check one Recovered Improved

Unchanged Retrogressed

(b) Is patient Ambulatory? House confined?

Bed confined? Hospital confined?

(c) If hospital confined, name of hospital _____

(d) Is this patient capable of self-sustaining employment? Yes No

Explain _____

6. PHYSICAL IMPAIRMENT

- Class 1 - No limitation of functional capacity; capable of heavy physical activity. No restrictions. (0-10%)
- Class 2 – Slight limitation of functional capacity; capable of light manual activity. (15-30%)
- Class 3 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (35-55%)
- Class 4 – Marked limitation. (60-70%)
- Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary) activity. (75-100%)

Remarks: _____

7. INTELLECTUAL IMPAIRMENT

- None (IQ 85 and above)
- Borderline (IQ 71 to 84)
- Mild (IQ 50 to 70)
- Moderate (IQ 35 to 49)
- Severe/Profound (IQ 34 and below)

Remarks: _____

8. SOCIAL IMPAIRMENT (personal/social skills)

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

Remarks: _____

9. PROGNOSIS

(a) Do you expect a fundamental or marked improvement in the future?

Yes No

(b) If yes, when will patient recover sufficiently to become employed?

Month_____/Day_____/Year_____ 1 Mo. 1-3 Mos. 3-6 Mos.

Other _____

(c) If no improvement expected, please explain: _____

10. CARDIAC (If Applicable)

- (a) Functional capacity Class 1 (No Limitation)
 Class 2 (Slight Limitation)
 Class 3 (Marked Limitation)
 Class 4 (Complete Limitation)

(b) Blood Pressure _____ / _____
Systolic Diastolic

11. REMARKS AND SUGGESTIONS (i.e., additional studies, consultations, vocational training, etc.)

Attending Physician (Print) Telephone

Address City State Zip Code

Signature Date