WHITMAN COUNTY LEOFF I BOARD
400 N Main Street, Colfax, WA 99111
(509) 397-5246
FAX (509) 397-6355

HEALTH CARE PROVIDER'S STATEMENT

(To be completed by physician or primary health care provider during the first or second appointment.) It is the sole responsibility of the employee to turn the form into the LEOFF I Board.

PATIENT: _____ SSN: _____
EMPLOYER: _____ INSURANCE/HMO: _____
ADDRESS: _____

Has insurance been billed by your office? Yes _____ No _____

PROVIDER: _____
ADDRESS: _____ PHONE: _____

Diagnosis: I have examined and treated the above-named LEOFF 1 member/claimant for the following medical condition(s):

_____
_____

Etiology: The cause of the condition is:

_____
_____

Treatment: I have prescribed or performed the following treatment on the dates indicated. (Note: For mental health, chiropractic and substance abuse treatment exceeding one month, a treatment plan MUST be submitted. Attach WCL1B #5, "Health Care Provider Treatment Plan".)

_____
_____

**Physician please answer the following:

1. Is patient able to perform his duties of _____ with average efficiency?

_____ I have received a copy of the job functions.

2. In your opinion, is disability duty or non-duty related? Please elaborate.

_____
_____

3. According to medical evidence, will the disability be permanent? Please elaborate.

_____
_____

The services rendered by me and the medication, appliances or other therapies, which I prescribed, were necessary medical services in view of the patient's diagnosis and condition.

Signature of Provider: _____ Date: _____

WCLIB #4