Support from a current treating physician is vital to a disability claim.

We recommend that you take this form to your most supportive doctor to complete.

It is not necessary to set up a special exam and incur personal expense to have this form completed.

1. This form MUST be signed and dated by the treating physician. Please be sure the name of the doctor completing this questionnaire is printed legibly on the top left-hand corner of the page.

2. Explain to the doctor that this form is designed to support their medical records and your claim for disability. The form can be filled out based on your doctor's existing knowledge of your condition.

3. Your doctor should know that this is not a litigation issue or a Workers' Compensation issue. Assure them that this is strictly for Social Security Disability Insurance (SSDI) and will not involve court appearances, depositions, or cross examination. Much of the concern the doctors have with completion of this form is a fear of legal issues.

4. Please have your doctor complete this form within three weeks of the date you receive this letter. Please return this form along with a copy of your last office visit. Thereafter, we will reevaluate your case to determine our continued involvement.

If your doctor will not complete this form, or we find that your doctor is not supportive of your disability, we may not be able to continue to represent you.

If your doctor is requesting more time to complete this form or there are questions about the form, please contact us as soon as possible at **(866) 502-8372.** Thank you.

Physical Capacity Questionnaire

Patient Name (*please print*): ______________________________ Date of Birth:_____________

Physician Name (*please print*): ____

Specialty (*please print*): ____

Date first seen: ____

Date last seen: ____

Diagnoses: ____

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1. Is your patient able to perform work requiring the following exertion on a regular and continuing basis (8 hour workday, 40 hour workweek), without an unusual number and length of rest periods relating to his/her medical condition(s)?
   - Standing and/or walking up to **2 hours** of an 8-hour day, and
   - Sitting **6 or more hours** of an 8-hour day, and
   - Lifting and/or carrying up to **10 pounds** "occasionally." *(Occasionally is defined as up to 2.6 hours per day)*, and
   - Lifting and/or carrying up to **a few pounds** "frequently." *(Frequently is defined as up to 5.3 hours per day).*

   Yes ☐ No ☐

2. Is the patient's impairment(s) expected to remain **at least** at this level of severity for at least the next 12 months or 12 months since work cessation?

   Yes ☐ No ☐

3. Please describe the objective and clinical findings that support your opinions:

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Please include a copy of medical notes from the last office visit with this patient.

____ ____________________________

Physician's Signature Date

If you are a healthcare professional and would like to know more about the SSDI process
and how Allsup supports your patient, visit **allsupcares.com**