



2. Cont.	c. List the name and address of the doctor(s) who told you to return to work.	
	NAME	
ADDRESS		
d. What date did your doctor tell you that you could return to work? (Month, Day, Year)		e. Did the doctor restrict you to limited or part-time work? <input type="checkbox"/> Yes (If "yes", explain in Part VI.) <input type="checkbox"/> No

**PART II - INFORMATION ABOUT YOUR MEDICAL RECORDS**

**NOTE:** When completing Part II, provide a summary of all medical examinations and treatments which you have received in the last 12 months.

3.	List the name, address and telephone number of the doctor who has your latest medical records.	If you have not seen a doctor, check here $\longrightarrow$ <input type="checkbox"/>	
NAME		ADDRESS	
TELEPHONE NUMBER (Include area code)			
How often do you see this doctor?	Date you first saw this doctor (Month, Day, Year)	Date you last saw this doctor (Month, Day, Year)	
Reasons for visits (show illness or injury for which you had an examination or treatment)			
Type of treatment received or medicines received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE")			
a. Have you seen any other doctors? $\longrightarrow$		<input type="checkbox"/> Yes (If "yes", show the following.) <input type="checkbox"/> No	
NAME		ADDRESS	
TELEPHONE NUMBER (Include area code)			
How often do you see this doctor?	Date you first saw this doctor (Month, Day, Year)	Date you last saw this doctor (Month, Day, Year)	
Reason for visits (show illness or injury for which you had an examination or treatment)			
Type of treatment or medicines received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE")			
NAME		ADDRESS	
TELEPHONE NUMBER (Include area code)			
How often do you see this doctor?	Date you first saw this doctor (Month, Day, Year)	Date you last saw this doctor (Month, Day, Year)	
Reason for visits (show illness or injury for which you had an examination or treatment)			
Type of treatment received or medicines received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE")			

3. Cont.	NAME	ADDRESS		
	TELEPHONE NUMBER (Include area code)			
	How often do you see this doctor?	Date you first saw this doctor (Month, Day, Year)	Date you last saw this doctor (Month, Day, Year)	
	Reasons for visits (show illness or injury for which you had an examination or treatment)			
	Type of treatment or medicines received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE")			
4.	Have you been hospitalized or treated at a clinic for your disabling condition? _____		<input type="checkbox"/> Yes (If "yes", show the following.)	<input type="checkbox"/> No
	NAME OF HOSPITAL OR CLINIC		ADDRESS	
	PATIENT OR CLINIC NUMBER			
	Were you an inpatient (i.e., stayed at least overnight)? <input type="checkbox"/> Yes (If "yes", fill in the dates below.) <input type="checkbox"/> No		Were you an outpatient? <input type="checkbox"/> Yes (If "yes", fill in the dates below.) <input type="checkbox"/> No	
	DATES OF ADMISSIONS	DATES OF DISCHARGES	DATES OF VISITS	
	Reason for hospitalization or clinic visits (show illness or injury for which you had an examination or treatment)			
	Type of treatment or medicine received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE")			
	NAME OF HOSPITAL OR CLINIC		ADDRESS	
	PATIENT OR CLINIC NUMBER			
	Were you an inpatient (i.e., stayed at least overnight)? <input type="checkbox"/> Yes (If "yes", fill in the dates below.) <input type="checkbox"/> No		Were you an outpatient? <input type="checkbox"/> Yes (If "yes", fill in the dates below.) <input type="checkbox"/> No	
	DATES OF ADMISSIONS	DATES OF DISCHARGES	DATES OF VISITS	
Reason for hospitalization or clinic visits (show illness or injury for which you had an examination or treatment)				
Type of treatment or medicine received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE")				
If you have seen other doctors or if you have been in other hospitals or clinics for your illness or injury, list the names, addresses, patient or clinic numbers, dates and reasons for hospitalization or clinic visits in Part VI.				



8. HOUSEHOLD MAINTENANCE (cooking, cleaning, shopping, and odd jobs around the house as well as any other similar activities):

Cont.

RECREATIONAL ACTIVITIES AND HOBBIES (TV, radio, newspapers, books, fishing, bowling, musical instruments, etc.):

SOCIAL CONTACTS (visits with friends, relatives, neighbors, church, social clubs):

OTHER (drive car, motorcycle, ride bus or subway, etc.):

9. Have you attended (trade, vocational or academic) school or had any other type of vocational training since you began receiving disability benefits?

Yes (If "yes", explain below.)

No

10. Are you attending school?

Yes (If "yes", show the following.)

No

NAME OF SCHOOL

ADDRESS OF SCHOOL

CURRENT GRADE

**PART IV - INFORMATION ABOUT THE WORK YOU DID**

When completing Part IV provide information since date you became disabled.

11. Since you became disabled, have you done any work?

Yes (If "yes", show the following for each work attempt, no matter how short it was.)

No

JOB TITLE (Be sure to begin with your usual job)	TYPE OF BUSINESS	DATES WORKED (month/year)		DAYS PER WEEK	RATE OF PAY (Per hour, day, week, month or year)
		FROM	TO		
					\$
					\$
					\$





**PART VII - AUTHORIZATION AND NOTIFICATION STATEMENTS**

I understand that this report will be used to determine whether to continue or to stop my disability benefits. I also understand that if I am receiving Social Security disability benefits and Supplemental Security Income payments, this questionnaire is applicable to both claims.

- ▶ Copies of medical records may be provided to a physician or medical institution prior to my appearance for an independent medical examination if an examination is necessary.
- ▶ Results of any such independent examination may be provided to my personal physician.
- ▶ Medical information may be furnished to any contractor for transcription, typing, record copying, or other related clerical or administrative service performed for the State Disability Determination Service.
- ▶ The State Vocational Rehabilitation Agency may review any medical evidence for determining my eligibility for rehabilitative services.
- ▶ I agree to notify the Social Security Administration if my medical condition improves or I go to work.

NAME OF PERSON COMPLETING THIS FORM (Please print)	DATE FORM COMPLETED (Month, day, year)	TELEPHONE NUMBER (Include area code)
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MAILING ADDRESS (Number and Street, Apt. No., P.O. Box or Rural Route)

CITY AND STATE	ZIP CODE	NAME OF COUNTY (In which you now live)
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**PRIVACY ACT** (Continued from page 1): We may also use the information that you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

**PAPERWORK REDUCTION ACT:** This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 for the address. You may send comments on our estimate of the time needed to complete the form to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001. Send only comments relating to our time estimate to this address, not the completed form.**



