



CITY OF LINCOLN PHYSICIAN'S LONG TERM DISABILITY REPORT

Notice to Employee: This form must be completed by each physician you consulted for your disability. The completed form must be returned to the below address:

CITY OF LINCOLN
PERSONNEL DEPARTMENT, BENEFITS AREA
555 S. 10TH ST, SUITE 302
LINCOLN, NE 68508

Patient's Name _____ Date of Birth _____

Patient's Address _____

City _____ State _____ Zip _____

Phone (Area Code First) _____

MEDICAL CONDITION

- a. Primary, Secondary and Other Diagnosis: _____ ICD Codes _____
- b. Complications: _____
- c. Prognosis for a return to present occupation: _____
- d. Prognosis for a return to any employment: _____
- e. Is this a nervous or mental health condition? Yes _____ No _____

HISTORY

- a. When did symptoms first appear or accident happen? Month _____ Day _____ Year _____
- b. Date of first visit: Month _____ Day _____ Year _____
- c. Date of last visit: Month _____ Day _____ Year _____
- d. Date you first advised patient to cease work Month _____ Day _____ Year _____
- e. Is condition due to injury or sickness arising out of patient's employment? Yes _____ (*describe*) No _____

TREATMENT

- a. What are the treatment plans? _____
 - b. Surgery? _____
 - c. Medications: _____
 - d. Is further treatment required? _____
 - e. Hospitalizations? _____
- The Patient has been continuously disabled (*unable to work*) From _____ through _____.
- If still disabled, When should patient be able to return to work? Date _____
- Would job modification enable patient to work with impairment? Yes _____ (*describe*) No _____

Physician's Name _____

Physician's Address _____ City _____ State _____ Zip _____

Signature _____ Date _____