In the Court of Common Pleas of County, Pennsylvania

Phone: **Fax:**

Member Name:
Docket Number:
PACSES Case Number:
Other State ID Number:

Please note: All correspondence must include the PACSES Case Number.

PHYSICIAN VERIFICATION FORM

TO BE COMPLETED BY THE TREATING PHYSICIAN:

Physician's Name: _____

Physician's License Number: _____

Nature of patient's sickness or injury:

_____

_____

_____

(a) Date of first treatment: _____

(b) Date of most recent treatment: _____

(c) Frequency of treatments: _____

(d) Medication: _____

The patient has had a medical condition that affects his or her ability to earn income from:

_____ through _____

If the patient is unable to work, when should the patient be able to return to work? Will there be limitations?

_____

_____

REMARKS: _____

_____

Date: _____ Signed: _____
Signature of Treating Physician

I authorize my physician to release the above information to the County Domestic Relations Section.

_____
Physician's Address

_____

_____
Physician's Telephone Number

_____ _____

Patient's Signature **Date**

Form EN-015 07/15

Service Type

Worker ID