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'S INFORMATION REQUEST

TO BE COMPLETED BY ATTENDING PHYSICIAN:

Physician's Name: ______________________________

Nature of patient's sickness or injury (Describe complications, if any)

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(a) Date of first treatment: ______________________________

(b) Date of most recent treatment: ______________________________

(c) Frequency of treatments: ______________________________

(d) Medication: ______________________________

The patient has been continuously disabled (unable to work) from:

______________________ through ______________________

If still disabled, when should patient be able to return to work? Are there limitations?

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REMARKS: ______________________________

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Date: ______________________ Signed: ______________________
(Attending Physician)

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

____
Physician's Address

____

____
Patient's Signature

____
Date

Form EN-015

Service Type

Worker ID