MEDICAL TREATMENT

Claimant: _____ File No. _____
ANY AND ALL OTHER NAMES USED ON YOUR MEDICAL RECORDS: _____
_____

I am aware that I MUST NOTIFY SSA and MY ATTORNEY OF ALL MEDICAL PROVIDERS THAT I HAVE SEEN since the day I have alleged or will allege that I became disabled and all medical evidence that may exist whether it is favorable or unfavorable to my claim.

A. Doctors/Clinics --List all doctors and/or clinics gone to for physical and/or mental treatments since you became disabled. If you are treated at a clinic, for example Morton Comprehensive Health, and see multiple providers, you only need to list the clinic name and your main doctor (if you have one). You may attach additional pages if necessary to list all providers.

Doctor:_____
Clinic: _____
Address: _____
Phone: _____
Date began treatment with this provider: _____
Date of last visit with this provider: _____
I am being treated for: _____

Doctor:_____
Clinic: _____
Address: _____
Phone: _____
Date began treatment with this provider: _____
Date of last visit with this provider: _____
I am being treated for: _____

Doctor:_____
Clinic: _____
Address: _____
Phone: _____
Date began treatment with this provider: _____
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Clinic: _____
Address: _____
Phone: _____
Date began treatment with this provider: _____
Date of last visit with this provider: _____
I am being treated for: _____

B. **Hospitals -- List all HOSPITALS visits whether physical AND/OR mental treatment since you became disabled.**

Name of Hospital:_____
Address: _____
Phone: _____

Emergency Room visits at this facility

Date _____ Reason _____

Date _____ Reason _____

Date _____ Reason _____

Overnight hospital stays at this facility

Date in _____ Date out _____
Reason_____

Date in _____ Date out _____
Reason_____

Date in _____ Date out _____
Reason_____

Name of Hospital:_____
Address: _____

Phone: _____

Emergency Room visits at this facility

Date _____ Reason _____

Date _____ Reason _____

Date _____ Reason _____

Overnight hospital stays at this facility

Date in _____ Date out _____
Reason_____

Date in _____ Date out _____
Reason_____

Date in _____ Date out _____
Reason_____

Name of Hospital:_____
Address: _____
Phone: _____

Emergency Room visits at this facility

Date _____ Reason _____

Date _____ Reason _____

Date _____ Reason _____

Overnight hospital stays at this facility

Date in _____ Date out _____
Reason_____

Date in _____ Date out _____
Reason_____

Date in _____ Date out _____
Reason_____

C. **Have you worked for actual wages since you became disabled? If yes, please list below.**

Employer: _____ Address: _____
Job title:_____ Job duties: _____
Hourly wage:_____ No. hours worked per week: _____
Date work started:_____ Date work ended: _____

The above is a complete list of all medical providers since I became disabled. After submitting this form, I agree to update my attorney if I have any changes in my medical treatment for the above listed providers. I understand that it is possible that I may be exposed to civil monetary penalties or criminal penalties if I fail to disclose to SSA all of my medical treatment providers. I also understand that my attorney is **REQUIRED BY LAW** to submit all evidence relating to my disability claim whether it is favorable or unfavorable.

_____ _____
Signature Date