



APPLICANT NAME \_\_\_\_\_ SSN \_\_\_\_\_

**A. APPLICANT INFORMATION (continued)** To be completed and signed by the APPLICANT:

Physician/Healthcare Provider Information:

Physician Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

**Certification: I certify that the above information is true and complete to the best of my knowledge. I know that any misrepresentation herein may lead to a rejection of this application, and the Mississippi Attorney General's Office has the right to commence civil and/or criminal action for the misrepresentation of such information.**

\_\_\_\_\_  
**Applicant's Signature** **Date (mm/dd/yyyy)**

**If applicable, I signed on behalf of the applicant as legal representative. (Please attach a copy of documentation authorizing legal representation.)**

\_\_\_\_\_  
**Printed name of legal representative** **Signature of legal representative** **Date (mm/dd/yyyy)**

APPLICANT NAME \_\_\_\_\_ SSN \_\_\_\_\_

**B. EMPLOYMENT INFORMATION** To be completed and signed by your EMPLOYER.

Name of Employer: \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Email Address: \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Employee's Job Title: \_\_\_\_\_

Monthly salary \$ \_\_\_\_\_ Annual Salary \$ \_\_\_\_\_

**For the last full pay period worked, please include the following information:**

Pay Period (mm/dd/yyyy): From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

Dates employee worked after returning from injury leave period:

**From** \_\_\_\_/\_\_\_\_/\_\_\_\_ **To:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Has Workers' Compensation been re-applied for?  Yes  No Approved?  Yes  No

Name and address of Workers' Compensation carrier:

\_\_\_\_\_

**Is this the same condition reflected in the original claim?**  Yes  No

If yes, what are the restrictions/limitations preventing the employee from performing his or her regular duties: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**B. EMPLOYMENT INFORMATION (continued)** To be completed and signed by your EMPLOYER.

**Certification:** I certify that the employment information in Section B is true and complete to the best of my knowledge. I know that any misrepresentation herein may lead to a rejection of the employee’s application, and the Mississippi Attorney General’s Office has the right to commence civil and/or criminal action for the misrepresentation of such information. *Furthermore, I will notify the Mississippi Attorney General’s Office in writing the exact date the employee returns to work. This notification shall be submitted no later than ten days after the employee returns to work in the format prescribed by the Mississippi Attorney General’s Office.*

\_\_\_\_\_  
**Signature of Employer**                      **Job Title**                      **Date (mm/dd/yyyy)**



APPLICANT NAME \_\_\_\_\_ SSN \_\_\_\_\_

**C. PHYSICIAN'S CERTIFICATION** To be completed and signed by the PHYSICIAN treating you for this disability.

**Diagnosis/primary disabling condition:** \_\_\_\_\_

**Original dates unable to work:**

**Partial Duty:** From \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Full Duty:** From \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Revised dates unable to work:**

**Partial Duty:** From \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Full Duty:** From \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Anticipated return to work/release date:** \_\_\_\_\_ If undetermined, based on your medical knowledge, what is a reasonable time frame before you expect to be able to release this patient to return to work? \_\_\_\_\_

**Is this patient temporarily disabled?**  Yes  No If yes, what are the temporary restrictions/limitations? \_\_\_\_\_  
\_\_\_\_\_

**Certification: I certify that the above information is true and complete to the best of my knowledge. I know that any misrepresentation herein may lead to a rejection of the patient's application, and the Mississippi Attorney General's Office has the right to commence civil and/or criminal action for the misrepresentation of such information.**

**Signature of physician :** \_\_\_\_\_ **Date (mm/dd/yyyy)** \_\_\_\_\_

Name of physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_\_ **Tax ID or SSN:** \_\_\_\_\_

Address: \_\_\_\_\_

Email address: \_\_\_\_\_ **Patient #:** \_\_\_\_\_