

In the Court of Common Pleas of Berks County, Pennsylvania

Phone: (610) 478-2900

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

TO BE COMPLETED BY AN ADVANCED PRACTICE PROVIDER

Provider's Name: _____

Provider's License Number: _____

Provider's title (MD, DO, etc.) _____

Nature of patient's sickness or injury: _____

Date of first treatment: _____

Date of most recent treatment: _____

Frequency of treatments: _____

Medication: _____

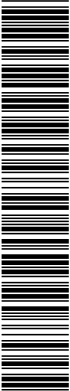
Due to the patient's medical condition, the patient can engage in the following types of work-related activity (mark all that apply):

Very heavy activity involving lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more, and the ability to perform heavy, medium, light, and sedentary activity.

Heavy activity involving lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds, and the ability to perform medium, light, and sedentary activity.

Medium activity involving lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds, and the ability to perform light and sedentary activity.

Light activity involving lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds, a good deal of walking or standing, or sitting with some pushing and pulling of arm or leg controls.



___ Sedentary activity involving lifting no more than 10 pounds at a time, occasionally lifting or carrying articles like docket files, ledgers, and small tools, sitting, and occasionally walking and standing.

___ None. Based on my assessment, I found that the patient's condition is such that he or she cannot engage in any type of work-related activity.

Please mark whether the patient's condition is ___ temporary or ___ permanent.

If the patient cannot engage in any type of work-related activity and the patient's condition is temporary, when should the patient be able to engage in any type of work-related activity _____

Will there be limitations? _____

Additional Remarks: _____

Signature of Treating Provider: _____ Date: _____

Provider's address: _____

Provider's telephone number: _____

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

Patient's signature: _____ Date: _____

