Internet PRO

Adult Disability & Work History Report - PRO

Help/FAQ

743-17-4176

About Your Organization

Please complete this report in English. Give the name and information about the person in your organization that Social Security should contact for more information about this claim, if needed. **This page does not replace the form SSA-1696-U4 Appointment of Representative**. If you are representing the claimant, you must still give us a completed SSA-1696-U4.
Items marked with an asterisk ( ) are required.

Organization Name:

Contact Name:

(First, Last)

Contact Instructions:

(300 characters maximum. About 6 lines. If you need more space, continue in the Remarks section at the end of this report.)

Count Characters You have entered 0 characters

Organization Address:

Please provide your complete address. Do NOT use punctuation marks.

(Street Address 1)

(Street Address 2)

(City, State, ZIP)

Contact Phone Number: ( ) -

Ext: (optional)

Email Address:

Continue

(800) 772-1213 or TTY (800) 325-0778, 7am-7pm

Sign Off   Edit Organization Profile   Help/FAQ

John Public   743-17-4176

About John Public: Medical, Work, and Education History

Items marked with an asterisk ( ) are required.

About the Claimant's Condition(s)

List all of the conditions that limit the claimant's ability to work:

(If there is more than one, list each on a separate line.)

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

When did the claimant's condition first interfere with his/her ability to work?

(whether he/she knew what the problem was at the time)

Do any of the conditions listed cause the claimant pain or other symptoms? Yes No

Did the claimant go to a doctor, hospital, clinic or anyone else for mental or Yes No

emotional problems that limit his/her daily activities?

Claimant's Work History

Has the claimant ever worked?

Yes, but stopped because of his/her condition
Yes, but stopped because of other reasons (not due to his/her condition)
Yes, but stopped both due to his/her condition and other reasons
Yes, currently working
No, has never worked

Claimant's Education and Special Job Training

How many years of school has the claimant completed?

Approximate date completed: (optional)

Has the claimant completed any type of special job training, trade or vocational school? Yes No

Has the claimant attended special education classes or received other education services beyond what is done in a regular classroom? Yes No

Has the claimant received vocational rehabilitation services or participated in the Ticket Program? Yes No

See revision

Previous Continue

(800) 772-1213 or TTY (800) 325-0778, 7am-7pm

Has the claimant participated or is the claimant participating in:	Yes	No
• an individual work plan with an employment network under the Ticket to Work Program;		
• an individualized plan for employment with a vocational rehabilitation agency or any other organization;		
• a Plan to Achieve Self-Support;		
• an individualized education program through an educational institution (if a student age 18-21); or		
• any program providing vocational rehabilitation, employment services, or other support services to help him or her go to work?		

Sign Off Edit Organization Profile Help/FAQ

John Public 743-17-4176

Work Status: **Stopped working**

Condition (s): Back Injury.

Important: Date John Public Became Unable to Work

Items marked with an asterisk ( ) are required.

When did the claimant become unable to work because of his/her condition?

Encourage the claimant to select the closest date he/she can remember.

When was the last day the claimant worked?

Encourage the claimant to select the closest date he/she can remember.

Did the claimant work at any time after the condition first interfered with his/her ability to work? **Yes** **No**

If the claimant said "Yes", then tell us whether or not claimant's condition caused him/her to make any changes. Please select all that apply.

Change job duties or find new ways to do the job
Change to a different employer
Work fewer hours
Take sick days or miss scheduled work time
Stop working for a period of time
Get extra help from employer, co-workers, or other employees
Make other changes to the work not listed above
Did not make any changes to his/her work

Explain in detail each type of change that was selected above. (if applicable)

(1000 characters maximum. About 20 lines. If you need more space, continue in the Remarks section at the end of this report.)

Count Characters You have entered 0 characters

Previous Continue

(800) 772-1213 or TTY (800) 325-0778, 7am-7pm

Sign Off Edit Organization Profile Help/FAQ

John Public 743-17-4176

Work Status: **Stopped working**

Condition (s): Back Injury.

plan or Program

Provide Vocational Rehabilitation Agency Details

or is participating plan or program

The claimant received vocational rehabilitation services or participated in a Ticket Program at the following place. If this is not true, please Change the Answer
Items marked with an asterisk ( ) are required.

Organization Name: Agency or School Name:

Counselor's Name: or Instructor's

(First, Last)

Address:

Please provide complete address. Do NOT use punctuation marks.

(Street Address 1)

(Street Address 2)

(Street Address 3)

(City, State, ZIP)

Phone Number: ( ) -
Ext: (optional)

Appointment Dates

When did the claimant first visit?

When did the claimant last visit?

Types of Services or Tests Performed:

(1000 characters maximum. About 20 lines. If you need more space, continue in the Remarks section at the end of this report.)

Count Characters You have entered 0 characters

The claimant had vocational rehabilitation services at another agency

Previous Continue

(800) 772-1213 or TTY (800) 325-0778, 7am-7pm