
DISABILITY UPDATE REPORT

PRIVACY ACT/PAPERWORK ACT NOTICE: The information requested on this form is authorized by the Social Security Act, Sections 205 (a) and 1631 (e) (1) (A) and (B), and regulations at 20 CFR 404.1589 and 416.989. The information provided will be used to further document your claim and permit a determination about your continuing disability. Information requested on this form is voluntary. However, if you do not provide the required information, a decision based on the evidence in your file can result in a determination that your period of disability is ceased. While the information you furnish on this form would almost never be used for any purpose other than making a determination about your disability, such information may be disclosed by SSA for the following purposes: (1) To assist SSA in determining the right to Social Security benefits for yourself or another person; (2) To facilitate statistical research and audit activities necessary to assure the integrity and improvement of programs administered by the Social Security Administration and another agency. Explanations about these and other reasons why information you provide us may be used or given out are available in the Social Security offices. If you want to learn more about this, contact any Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. To find the nearest office, call 1-800-772-1213. Send only comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401.**

Name and Address

Claim Number

1. Within the last 2 years have you worked for someone or been self-employed?

Yes _____ No _____

If yes, please complete the information below.

Work Began (month/year)	Work Ended (month/year)	Monthly Earnings
1. _____/_____/_____	_____/_____/_____	\$ _____
2. _____/_____/_____	_____/_____/_____	\$ _____
3. _____/_____/_____	_____/_____/_____	\$ _____

2. Check the block which best describes your health within the last 2 years:

Better _____ Same _____ Worse _____

3. Within the last 2 years has your doctor told you that you can return to work?

Yes _____ No _____

4. Within the last 2 years have you attended any school or work training program(s)?

Yes _____ No _____

5. Would you be interested in receiving rehabilitation or other services that could help you get back to work?

Yes _____ No _____

6. Within the last 2 years have you been hospitalized or had any surgery?

Yes _____ No _____

If yes, please list below:

Reason

Date: (month/year)

- 1. _____
- 2. _____
- 3. _____

7. Within the last 2 years have you gone to a doctor or clinic for your condition?

Yes _____ No _____

If yes, show the date and the reason for the visit.

- 1. Date _____
Reason _____
- 2. Date _____
Reason _____
- 3. Date _____
Reason _____

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGN
HERE ▶

Date

Telephone Number