

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:

Contact

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



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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

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- | | | |
|--|-----|----|
| Has the claimant participated or is the claimant participating in: | Yes | No |
| <ul style="list-style-type: none">• 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? | | |



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John Public 743-17-4176

Work Status: **Stopped working**

Condition Back Injury.
(s):

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.)

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When did the claimant last visit?

Types of Services (or) Tests, or Evaluations Performed:

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

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The claimant had ^{plans or programs elsewhere} vocational rehabilitation services at another agency

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