

iClaim-i3368 Marriage (1st Party): Screen Package 0.5

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Apply for Benefits

OMB No. 0000-0000
[Paperwork Reduction Act](#)

- 1 Provide Background Information
- 2 Provide Disability Information
- 3 Sign Medical Release
- 4 Confirmation

- Identification
- Medical
- Work/Education
- Remarks
- Review

Contact Information for Kelly Anderson

Mailing Address:

400 Cathedral Street, Apt 7A, Baltimore, Maryland 21201

Daytime Phone Number:

443 644 6789

Another phone number where we may reach you:

U.S. International

10-digit Number Ext.

E-mail Address:

Confirm E-mail Address:

In this section...

- Contact Information

Other Names

Have you used any other names on medical or educational records?

Examples: Maiden name, other married name, or nickname.

Yes No

1st Other Name:

First Middle Last Suffix

2nd Other Name:

First Middle Last Suffix

3rd Other Name:

First Middle Last Suffix

4th Other Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	-- ▾
First	Middle	Last	Suffix

5th Other Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	-- ▾
First	Middle	Last	Suffix

Next

Save & Exit



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- 3 Sign Medical Release
- 4 Confirmation

- Identification
- Medical
- Work/Education
- Remarks
- Review

Contact Information for Kelly Anderson

Mailing Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town: **State/Territory:** **ZIP Code:**

Daytime Phone Number:

U.S. International

10-digit Number Phone Type

Another phone number where we may reach you:

U.S. International

10-digit Number [Ext.](#)

E-mail Address:

Confirm E-mail Address:

In this section...

- Contact Information
- Re-entry Number

Other Names

Have you used any other names on medical or educational records?

Examples: Maiden name, other married name, or nickname.

Yes No

1st Other Name:

First Middle Last Suffix

2nd Other Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	-- ▾
First	Middle	Last	Suffix

3rd Other Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	-- ▾
First	Middle	Last	Suffix

4th Other Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	-- ▾
First	Middle	Last	Suffix


5th Other Name:


<input type="text"/>	<input type="text"/>	<input type="text"/>	-- ▾
First	Middle	Last	Suffix

Next

Save & Exit

37. Confirm Your Identity On Re-entry (1st party to 1st party)

Text Size  | Accessibility Help

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Apply for Benefits


Please Confirm Your Identity


I am:

- Kelly Anderson
- Someone else, helping Kelly Anderson to apply for benefits

Next

38.Re-entry Number (i3368 only)

| Text Size  | Accessibility Help



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Apply for Benefits

1 Provide Background Information**2** Provide Disability Information**3** Sign Medical Release**4** Confirmation


Identification Medical Work/Education Remarks Review

i You must print this page or write down the re-entry number.

Re-entry Number: **26748727**

If something causes you to exit or you choose to save and return at a later time, you must use this number to continue your saved application process.

If you lose this number, you will need to start a new application. Social Security employees will never ask for your re-entry number and they do not have access to it. This is to protect your privacy.

 [Print this Page](#)

In this section...

- Contact Information
- Re-entry Number

NextPreviousSave & Exit



Apply for Benefits

OMB No. 0000-0000
[Paperwork Reduction Act](#)

- 1 Provide Background Information
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- 3 Sign Medical Release
- 4 Confirmation

- Identification
- Medical
- Work/Education
- Remarks
- Review

Conditions for Kelly Anderson

List ALL the Physical or Mental Condition(s) (including emotional or learning problems) that limit your ability to work (Example: Back Injury, Arthritis, Diabetes, Glaucoma, Depression, Blind). We will consider these conditions whether or not you have been receiving treatment. Use your own words if you do not know the medical names. Please enter **only** one condition per box.

1st Condition:

2nd Condition:

3rd Condition:

4th Condition:

5th Condition:

6th Condition:

7th Condition:

8th Condition:

9th Condition:

10th Condition:

I have more than 10 conditions that limit my ability to work.

In this section...

- Conditions
- Other Contact
- Doctors
- Hospitals
- Tests
- Medicines
- Other Medical Records

What is your height without shoes?

Feet

Inches

What is your weight without shoes?

lbs

Does your condition cause you pain or other symptoms?

Yes No

Treatment

Have you seen a doctor or other healthcare professional or received treatment at a hospital or clinic or do you have a future appointment scheduled?

For any physical condition(s):

Yes No

For any mental condition(s):

Yes No

Next

Save & Exit



Apply for Benefits

- 1 Provide Background Information
- 2 Provide Disability Information**
- 3 Sign Medical Release
- 4 Confirmation

- Identification**
- Medical
- Work/Education
- Remarks
- Review

Someone Who Knows About Your Conditions

Give the name of someone we can contact who knows about your medical conditions and can help you with your claim. This may be a family member or friend who knows about your daily life. Do not include your doctor.

Do you know someone we can contact about your condition?

- Yes
- No

Name:

First Middle Last Suffix

Relationship to You:

--

What is the address of this person?

- Same as my address: 400 Cathedral St, Apt 7A, Baltimore, MD 21201
- Enter a different address:

Address:

Street Line 1: Street Line 2: + Add More Lines

City/Town: State/Territory: ZIP Code:

What is the daytime phone number of this person?

- Same as my phone number: 443-644-6789
- Enter a different daytime phone number:

Daytime Phone Number:

U.S. International
10-digit Number Ext.

In this section...

- Conditions
- Other Contact
- Doctors
- Hospitals
- Tests
- Medicines
- Other Medical Records

Preferred Language


Can this person speak and understand English?

Yes No

Next

Previous

Save & Exit

| Text Size  | Accessibility Help



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1 Provide Background Information 2 Provide Disability Information 3 Sign Medical Release 4 Confirmation


Identification Medical Work/Education Remarks Review

Someone Who Knows About Your Conditions

Give the name of someone we can contact who knows about your medical conditions and can help you with your claim. This may be a family member or friend who knows about your daily life. Do not include your doctor.

Do you know someone we can contact about your condition?

Yes No

 **We recommend that you provide a contact, if available.**

Having the name of someone who knows you may help us make a quicker decision on your claim. Doctors and hospitals may not have a complete picture of how your conditions affect your daily life and your work.

Please select "Yes" above if you want to change your answer.

In this section...

- Conditions
- Other Contact
- Doctors
- Hospitals
- Tests
- Medicines
- Other Medical Records

Next

Previous

Save & Exit

41.Doc001-1_Doctors and healthcare professionals

Text Size | Accessibility Help



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Apply for Benefits

1 Provide Background Information 2 Provide Disability Information 3 Sign Medical Release 4 Confirmation

Identification Medical Work/Education Remarks Review

Doctors and Other Healthcare Professionals for Kelly Anderson

If you do not have any more **doctors/healthcare professionals** to enter, click the Next button.

- If you were an inpatient or outpatient at a hospital or clinic, do not list staff doctors. We will ask about them later.
- Include only the people who have treated you for the conditions related to your disability.
- Give each person's first and last name if possible.

	Doctors/Healthcare Professionals	City	Phone	Actions
<input checked="" type="checkbox"/>	Dr. Samantha Gupta	Baltimore, MD	(410) 496-9643	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

In this section...

- Conditions
- Other Contact
- Doctors
- Hospitals
- Tests
- Medicines
- Other Medical Records

42.Doc002-1_Doctors and healthcare professionals details



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Apply for Benefits

Doctor/Healthcare Professional Details

Name of Doctor/Healthcare Professional: [? More info](#)

<input type="text"/>	<input type="text"/>	<input type="text"/>
First	Last	Suffix

Office Name or Clinic, if applicable:

Doctor/Healthcare Professional's Address:

If you don't have the full street address, give us as much as you can.
Example: "On Main St next to the Courthouse"

Country:

Street Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town:

State/[Territory]:

ZIP Code:

Doctor/Healthcare Professional's Phone Number:

U.S. International

<input type="text"/>	<input type="text"/>
10-digit Number	Ext.

Patient ID Number, if known:

Treatment Dates with this Doctor/Healthcare Professional

Please give us the closest date(s) you can remember. [? More info](#)

First visit:

Last visit:

Next visit:

Leave blank if no appointment scheduled.

Tests Ordered by this Doctor/Healthcare Professional

[? More info](#)

Has this doctor/healthcare professional ordered any tests for you?

This includes any medical tests you have had or will have.

Yes No

Details about Test 1:

Kind of Test:

Date of Test: [? More info](#)

This doctor/healthcare professional ordered this test for me more than once.

Details about Test 2:

Kind of Test:

Date of Test: [? More info](#)

This doctor/healthcare professional ordered this test for me more than once.

If you have more tests, we will ask for them later in the process.

Medicines Recommended or Prescribed by this Doctor/Healthcare Professional

Has this doctor/healthcare professional recommended or prescribed any medicines for you?

Yes No

List any medicines you are taking and the reasons you are taking them.

List only one medicine at a time. Look at the medicine container if necessary.

Medicine 1:

Reason 1:

Medicine 2:

Reason 2:

Medicine 3:

Reason 3:

If you have more medicines, we will ask for them later in the process.

Medical Conditions Treated by this Doctor/Healthcare Professional

What medical conditions were treated or evaluated by this doctor/healthcare professional?

Examples: back injury, arthritis, diabetes, depression, blind. (1000 characters maximum)

Characters remaining: XXXX

Check Spelling

Treatment from this Doctor/Healthcare Professional

What treatment did you receive from this doctor/healthcare professional?

You DO NOT need to repeat any information that you have already told us about medicines and tests.

Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: XXXX


Check Spelling

Save

Cancel

43.Hos001-1_Hospitals and Clinics

Text Size Accessibility Help

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Apply for Benefits

1 Provide Background Information 2 Provide Disability Information 3 Sign Medical Release 4 Confirmation

Identification Medical Work/Education Remarks Review

Hospitals and Clinics for Kelly Anderson

If you do not have any more **hospitals/clinics** to enter, click the Next button.

Include all hospitals and clinics where you have been treated for the condition(s) related to your disability.

Hospitals and Clinics	City	Phone	Actions
<input checked="" type="checkbox"/> Vancouver General Hospital	Vancouver, BC	(604) 875-4111	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

In this section...

- Conditions
- Other Contact
- Doctors
- Hospitals
- Tests
- Medicines
- Other Medical Records

44.Hos002-1_Hospital and Clinic Details



Apply for Benefits

Hospital/Clinic Details

Name of Hospital/Clinic:

Name of Healthcare Professional who treated you, if known:

Address:

If you don't have the full street address, give us as much as you can.
Example: "On Main St next to the Courthouse"

Country:

Street Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town:

State/Territory:

ZIP Code:

Hospital/Clinic Phone Number:

U.S. International

10-digit Number [Ext.](#)

Hospital/Clinic Record Number, if known:

Treatment Dates at this Hospital/Clinic

[? More info](#)

Did you have any emergency room (ER) visits at this hospital/clinic?

ER Visit means you went to the ER and then went home.

Yes No

Treatment from this Hospital/Clinic

What treatment did you receive for the above at this hospital/clinic?

You DO NOT need to repeat any information that you have already told us about medicines and tests.
Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: XXXX

Check Spelling

Save

Cancel

45.Tst001-1_Medical tests



Apply for Benefits

- 1 Provide Background Information
- 2 Provide Disability Information
- 3 Sign Medical Release
- 4 Confirmation

- Identification
- Medical
- Work/Education
- Remarks
- Review

Medical Tests for Kelly Anderson

If you do not have any **medical tests** to enter, click the **Next** button.

	Name of the Test	Test ordered by	Actions
<input checked="" type="checkbox"/>	EKG (Heart Test)	Doctor(s) at Vancouver General Hospital	<input type="button" value="Edit"/> <input type="button" value="Delete"/>
<input checked="" type="checkbox"/>	X-ray (Body part)	Doctor(s) at Vancouver General Hospital	<input type="button" value="Edit"/> <input type="button" value="Delete"/>


- In this section...**

 - Conditions
 - Other Contact
 - Doctors
 - Hospitals
 - Tests
 - Medicines
 - Other Medical Records

- Next**
- Previous
- Save & Exit

46.Tst002-1_Medical Test Details

Text Size Accessibility Help

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Test Details

Kind of Test:
--

Date of Test: [? More info](#)
[]

Who sent you or will send you for this test?
If the provider's name is not in the list, select "Other Medical Professional."
--

This provider ordered this test more than once.

Save Cancel



Apply for Benefits

Test Details

Kind of Test:

Date of Test: [? More info](#)

Who sent you or will send you for this test?

If the provider's name is not in the list, select "Other Medical Professional."

Add Doctor/Healthcare Professional

Add Hospital/Clinic

This provider ordered this test more than once.

Save

Cancel

Note: When user selects "Other Medical Professional" in the dropdown for "Who sent you...", the buttons "Add Doctor/Healthcare Professional" and "Add Hospital/Clinic" are displayed on the screen. It is mandatory for the user to select either of the buttons in order to continue.

When user selects either of the buttons, he is taken to Doctor or Hospital details page. Any action on the Doctor or Hospital details page should navigate them to the Tests page (Tst001-1_Medical tests)

47.Med001-1_Medicines

| Text Size  | Accessibility Help



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Apply for Benefits

1  Provide Background Information2  Provide Disability Information3  Sign Medical Release4  Confirmation

Identification Medical Work/Education Remarks Review

Medicines for Kelly Anderson


If you do not have any **medicines** to enter, click **Next** button. Please make sure to include all the prescription and over the counter medicines that you are taking.


	Name of Medicine	Reason	Prescribed/ Recommended by	Actions
<input checked="" type="checkbox"/>	Singular	COPD	Dr. Samantha Gupta	<input type="button" value="Edit"/> <input type="button" value="Delete"/>
<input checked="" type="checkbox"/>	Plavix	Heart Disease	Dr. Samantha Gupta	<input type="button" value="Edit"/> <input type="button" value="Delete"/>
<input checked="" type="checkbox"/>	Cymbalta	Depression	Dr. Elijah Saunders	<input type="button" value="Edit"/> <input type="button" value="Delete"/>
<input checked="" type="checkbox"/>	Tylenol	Pain	No one prescribed this medicine	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

In this section...

- Conditions
- Contact
- Doctors
- Hospitals
- Tests
- Medicines
- Other Medical Records

48.Med002-1_Medicine Details

| Text Size  | Accessibility Help



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Medicine Details

Enter name of the medicine:
Enter only one medicine at a time. Look at the medicine container if necessary.

What is the reason you are taking this medicine?

Who recommended or prescribed this medicine?
If this doctor's name is not in the list, select "Other Medical Professional."



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Medicine Details

Enter name of the medicine:

Enter only one medicine at a time. Look at the medicine container if necessary.

What is the reason you are taking this medicine?

Who recommended or prescribed this medicine?

If this doctor's name is not in the list, select "Other Medical Professional."

Add Doctor/Healthcare Professional

Add Hospital/Clinic

Save

Cancel

Note: When user selects “Other Medical Professional” in the dropdown for “Who recommended...”, the buttons “Add Doctor/Healthcare Professional” and “Add Hospital/Clinic” are displayed on the screen. It is mandatory for the user to select either of the buttons in order to continue.

When user selects either of the buttons, he is taken to Doctor or Hospital details page. Any action on the Doctor or Hospital details page should navigate them to the Medicines page (Med001-1_Medicines)

49.Msc001-1_Other medical records



Apply for Benefits

- 1 Provide Background Information
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- Identification
- Medical
- Work/Education
- Remarks
- Review

Other Medical Records for Kelly Anderson

Although this does not apply to everyone, some people may have relevant Medical records in other places. These other medical records may be available from:

- vocational rehabilitation services
- worker's compensation
- public welfare
- doctors in a prison or jail
- records held by an attorney or lawyer or
- medical records at another place

These other records may contain important information that we need to consider in evaluating the disability application.

Note: You do not need to list any organization that you have already mentioned.

If you do not have any more sources of **other medical records**, please click the **Next** button.

Name of Organization/Office	City	Phone	Actions
No Organization/Office information has been added.			

Add

- In this section...
- Conditions
 - Other Contact
 - Doctors
 - Hospitals
 - Tests
 - Medicines
 - Other Medical Records

- Next
- Previous
- Save & Exit

50.Msc002-1_Other Medical Record Details



Apply for Benefits

Other Medical Records Details

Name of Place:

Name of Contact:

First

Last

Address:

If you don't have the full street address, give us as much as you can.
Example: "On Main St next to the Courthouse"

Country:

Street Address:

Street Line 1:

Street Line 2: [+ Add More Lines](#)

City/Town:

State/[Territory]:

ZIP Code:

Daytime Phone Number:

Include area code.

U.S. International

10-digit Number

[Ext.](#)

First visit:

Please give us the closest date you can remember.

Last visit:

Please give us the closest date you can remember.

Next visit:

Leave blank if no appointment scheduled.

Case Number, if any:

Reasons for Visits or Services:

If you need more space, continue in the Remarks tab. (1000 characters maximum)

Characters remaining: XXXX

Check Spelling

Save

Cancel

51.



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Work Status for Kelly Anderson

In determining whether you meet the requirements for receiving disability benefits, we must consider your work experience and job skills. [More info](#)

This section of the report asks for information about:

- when your condition(s) began to affect your ability to work;
- your 5 most recent jobs; and
- your education and training.

Please give as much information as you can. We will contact you later if we need more information.

Are you currently working?

- No, I have never worked
- No, I have stopped working
- Yes, I am currently working

In this section...

- Work Status
- Work Activity
- Job History
- Education

- Next**
- Previous
- Save & Exit



Apply for Benefits

- 1 Provide Background Information
- 2 Provide Disability Information
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- Identification
- Medical
- Work/Education
- Remarks
- Review

Work Activity for Kelly Anderson

We need to know more about your reasons for stopping work and whether you made any changes in your work as a result of your condition(s).

When did you stop working?

If you don't know the exact date, enter the closest date you can remember.

Month Day Year

Why did you stop working?

- Because of my condition
- Because of my condition AND other reasons
- Because of other reasons

Please explain the other reasons why you stopped working.

[More info](#)

Text input field for explaining other reasons.

Characters remaining: 1000

Check Spelling

Even though you stopped for other reasons, when do you believe that your condition(s) became severe enough to keep you from working?

Month Day Year

Did your condition(s) cause you to make changes in your work activity before you stopped working? [More info](#)

- Yes
- No

In this section...

- Work Status
- Work Activity
- Job History
- Education





- Next
- Previous
- Save & Exit



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- Identification
- Medical
- Work/Education
- Remarks
- Review

Work Activity for Kelly Anderson


We need to know if you made any changes in your work as a result of your condition. If so, this may help show how your ability to work was limited because of a disability. [? More info](#)

Has your condition(s) caused you to make changes to your work activity?

- Yes
- No

When did you make changes?

If you don't know the exact date, enter the closest date you can remember.

--  --  -- 


Month Day Year


In this section...

- Work Status
- Work Activity
- Job History
- Education

- Next**
- Previous
- Save & Exit

55.Wac001-1-nw_Work Activity





| Text Size  | Accessibility Help



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Apply for Benefits

1  Provide Background Information2  Provide Disability Information3  Sign Medical Release4  Confirmation

Identification Medical Work/Education Remarks Review

Work Activity for Kelly Anderson

When do you believe your condition(s) became severe enough to keep you from working (even though you have never worked)?
If you don't know the exact date, enter the closest date you can remember.

Month

Day

Year

[Next](#)[Previous](#)[Save & Exit](#)





In this section...

- [Work Status](#)
- [Work Activity](#)
- [Job History](#)
- [Education](#)

56.Job001-1-sw_Job History



Apply for Benefits

- 1  Provide Background Information
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- Identification
- Medical
- Work/Education
- Remarks
- Review

Job History for Kelly Anderson

List the jobs (up to 5) that you have had in the past 15 years before you became unable to work because of your physical and/or mental conditions. Start with your most recent job.

Select the number of jobs you have had in the past 15 years before you became unable to work:

In this section...

Work Status

Work Activity

Job History

Education

Most Recent Job

Job Title:

Type of Business:

Start Date:

Month Year

End Date:

Month Year

Hours per Day:

Days per Week:

Rate of Pay:

\$
 Amount Frequency

Job Details

Describe this job, what did you do all day?

If you need more space use the Remarks tab. (1000 characters maximum)

Characters remaining: XXXX

Check Spelling

In this job, did you use machines, tools or equipment?

Yes No

In this job, did you use technical knowledge or skills?

Yes No

In this job, did you do any writing, complete reports, or perform any duties like this?

Yes No

In this job, how many hours each day did you do each of the tasks listed below?

Do not include breaks and lunch.

Did you walk?

Yes No

How many hours did you walk?

0.5 hours

Did you stand?

Yes No

You answered you did not stand.

Did you sit?

Yes No

How many hours did you sit?

3 hours

Did you climb?

Yes No

You answered you did not climb.

Did you stoop (bending down & forward at the waist)?

Yes No

Did you kneel (bending legs to rest on knees)?

Yes No

Did you crouch (bending legs & back down & forward)?

Yes No

Did you crawl?

Yes No

Did you handle large objects?

Yes No

How many hours did you handle large objects?

0.5 hours

Did you write, type or handle small objects?

Yes No

How many hours did you write, type or handle small objects?

3 hours

Did you reach?

You answered you did not reach.

Yes No

Please describe what you lifted, how far you carried things, and how often you were required to do so in your job:

If you need more space use the Remarks tab. (1000 characters maximum)

Characters remaining: 1000

[Check Spelling](#)

How heavy were the items you frequently lifted (1/3 to 2/3 of the work day) in this job?

What was the heaviest weight you ever lifted in this job?

Did you supervise other people in this job?

Yes No

How many people did you supervise?

What part of your time did you spend supervising people?

Did you hire and fire employees?

Yes No

Were you a lead worker?

Yes No

[Next](#)

[Previous](#)

[Save & Exit](#)

57.Job001-1-cw_Job History



Apply for Benefits

- 1 Provide Background Information
- 2 Provide Disability Information
- 3 Sign Medical Release
- 4 Confirmation

- Identification
- Medical
- Work/Education
- Remarks
- Review

Job History for Kelly Anderson

Since May 2, 2005, have you had gross earnings greater than \$830 in any month? Do not count sick leave, vacation, or disability pay.

We may contact your for more information.

- Yes
- No

- In this section...
- Work Status
 - Work Activity
 - Job History
 - Education

Job Listing

List the jobs (up to 5) that you have had in the past 15 years. Start with your most recent job.

Select the number of jobs you have had in the past 15 years:

1

Most Recent Job

Job Title:

Type of Business:

Start Date:

-- --

Month

Year

End Date:

-- --

Month

Year

Hours per Day:

Days per Week:

Did you write, type or handle small objects?

Yes No

How many hours did you write, type or handle small objects?

3 hours

Did you reach?

Yes No

You answered you did not reach.

Please describe what you lifted, how far you carried things, and how often you were required to do so in your job:

If you need more space use the Remarks tab. (1000 characters maximum)

Characters remaining: 1000

Check Spelling

How heavy were the items you frequently lifted (1/3 to 2/3 of the work day) in this job?

--

What was the heaviest weight you ever lifted in this job?

--

Did you supervise other people in this job?

Yes No

How many people did you supervise?

What part of your time did you spend supervising people?

Did you hire and fire employees?

Yes No

Were you a lead worker?

Yes No


Next

Previous

Save & Exit

58.Job001-1-nw_Job History

Text Size Accessibility Help

 **Social Security**
Official Website of the U.S. Social Security Administration

Apply for Benefits

1 Provide Background Information 2 Provide Disability Information 3 Sign Medical Release 4 Confirmation

Identification Medical Work/Education Remarks Review

Job History for Kelly Anderson

In an earlier question, you indicated that you have never worked. If this is incorrect, please

[Change Your Answer](#)

Based upon your previous answer, you do not need to enter information on this page.

Next Previous Save & Exit

In this section...

- Work Status
- Work Activity
- Job History
- Education

59.Edu001-1_Education and Training



Apply for Benefits

- 1 Provide Background Information
- 2 Provide Disability Information
- 3 Sign Medical Release
- 4 Confirmation

- Identification
- Medical
- Work/Education
- Remarks
- Review

Education and Training for Kelly Anderson

Highest Grade Completed:

If you did not complete the entire school year, select the previous year that you completed.

Date Completed:

Enter the date when you most recently completed a school year as close as you can remember.

Have you completed any type of special job training, trade or vocational school?

- Yes
- No

In this section...

- Work Status
- Work Activity
- Job History
- Education

Special Education

Did you attend special education classes? [More Info](#)

- Yes
- No

Language

Can you speak and understand English?

If you cannot speak and understand English, we will provide an interpreter free of charge.

- Yes
- No

Can you read and understand English?

- Yes
- No

Can you write more than your name in English?

- Yes
- No

- Next
- Previous
- Save & Exit



Apply for Benefits

- 1 Provide Background Information
- 2 Provide Disability Information
- 3 Sign Medical Release
- 4 Confirmation

- Identification
- Medical
- Work/Education
- Remarks
- Review

Remarks for Kelly Anderson

Please provide any additional information you want to include:

Characters remaining: 2000

In this section...

- Remarks



Apply for Benefits

- 1 Provide Background Information
- 2 Provide Disability Information
- 3 Sign Medical Release
- 4 Confirmation

- Identification
- Medical
- Work/Education
- Remarks
- Review

Review Information for Kelly Anderson

If you need to make any changes, please select the "Edit" button to return to that page.

Identification

[Edit](#) Personal Information

Personal Information

Name: **Kelly G. Anderson**
 Gender: **Female**
 Mailing Address: **400 Cathedral Street, Apt 7A, Baltimore, MD 21201**
 Daytime Phone: **443 644 6789**
 Extension:
 Alternate Phone: No
 E-Mail Address: **KGAnderson@yahoo.com**
 Other Names Used on Medical or Educational Records: **Yes**
 Other Name 1: **Kelly Gonzales**

Medical

[Edit](#) Conditions


List of physical and mental conditions:

- 1: **Type 2 diabetes**
- 2: **Chronic Shortness of Breath**
- 3: **Heart Disease**
- 4: **Depression**
- 5: **Pain**
- 6:
- 7:
- 8:
- 9:
- 10:

Height without shoes: **5' 8"**
 Weight without shoes: **260 lbs**
 Conditions cause pain or other symptoms: **Yes**

Seen a healthcare provider or received treatment, or have an appointment scheduled:
 For physical conditions: **Yes**

For mental conditions: **Yes**

[Edit](#)  **Someone who knows about your condition**

Someone who knows about your conditions

Name: **Jamie Gonzales**


Relationship: **Sister**

Mailing Address: **210 Main Street, Baltimore, MD 21228**

Daytime Phone Number: **210-111-2342**

Extension:

Speak and Understand English: **Yes**

[Edit](#)  **Doctors and Other Healthcare Professionals**

Doctor/Healthcare Professional 1

Name: **Dr. Samantha Gupta**

Address: **B900 Caton Avenue, Suite 301, Baltimore MD 21229**

Phone Number: **410-496-9643**

Extension:

First Visit: **Sometime in 1999**

Last Visit: **March 16, 2012**

Next Scheduled Appointment:

Medical conditions treated: **Diabetes, Heart Disease, COPD**

Treatments Received: **Singulair, Plavix**

Doctor/Healthcare Professional 2

Name: **Dr. Elijah Saunders**

Address: **2200 Kernan Drive, Rm 4611, Baltimore, MD 21207**

Phone Number: **410-328-4266**

Extension:

First Visit: **November 10, 2011**

Last Visit: **March 27, 2012**

Next Scheduled Appointment: **October 3, 2012**

Medical conditions treated: **Depression, Pain Management**

Treatments Received: **Cymbalta**

[Edit](#)  **Hospitals and Clinics**

Hospital/Clinic 1

Name: **Vancouver General Hospital**

Address: **855 West 12th Avenue, Vancouver, BC V5Z 1M9**

Phone Number: **604-875-4111**

Extension:

Emergency Room Visits: **Yes**

Emergency Room Visit 1 : **October, 2008**

Inpatient Stays: **No**

Outpatient Visits: **No**


Medical conditions treated: **Heart attack**

Treatment Received:

[Edit](#)  **Tests**

Hours per day: **12**
Days per week: **4**
Rate of pay: **90,000**
Frequency of pay: **Yearly**


Job Description: --
Equipment used: **No**
Technical knowledge used: **Yes**
Completed reports: **Yes**
Walking: **1 hour**
Standing: **4 hours**
Sitting: **1 hour**
Climbing: **0 hour (Never)**
Stooping: **0 hour (Never)**
Kneeling: **0 hour (Never)**
Crouching: **0 hour (Never)**
Crawling: **0 hour (Never)**
Handling large objects: **0 hour (Never)**
Writing, typing or handling small objects: **1 hour**
Reaching: **1 hour**
Description of lifting and carrying: --
Weight of frequently lifted items: **Less than 10 lbs**
Maximum weight lifted: **Less than 10 lbs**
Supervise others: **No**
Lead worker: **No**

[Edit](#)  **Education**

Education and Training


Highest grade of school completed: **4 years of college**
Date completed: **1988**
Any special training, trade, or vocational school: **No**
Special education: **No**
Speak in English: **Yes**
Read in English: **Yes**
Write in English: **Yes**

Remarks

[Edit](#)  **Remarks**

Remarks

Additional information:

 **You will not be able to change your information once you continue to Step 3.**
When you select "Accept & Continue" below, you will have completed Step 2. Please make sure that everything you have provided is correct before you continue to Step 3.

[Accept & Continue](#)

[Previous](#)

[Save & Exit](#)

