

Disability Case Selection

SSA Disability Claims System - Microsoft Internet Explorer provided by IE6.0 sP1>Alpha CI X

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Disability Case Selection [Enable JAWS Mode](#)

Search Criteria

Client SSN:

Client Name. Last: First:

Search Results

	Client Name	DSI	CEF	DOB	Estab Date	Level	Claim Type	Office Code	Office Type	Claim Status
<input type="radio"/>	XXXXX-XXXXX	N	Y	06/XX/1993	07/31/2005	Reconsideration	DI	X33	FO	Closed
<input type="radio"/>	XXXXX-XXXXX	N	Y	06/XX/19XX	07/31/2005	Initial	DI	C65	FO	Closed

Select Case Level

Select Case Level -- Web Page Dialog

No EDCS case found. Please select the adjudicative level at which you want the case to be established.

Initial Classification:

- Initial
- Reconsideration
- Hearing
- Appeals Council
- Federal Court

MCS Exclusion Claim

CDR Classification:

- CDR Initial
- CDR Reconsideration
- CDR Hearing

OK Cancel

Confirm Case Creation

Confirm Case Creation -- Web Page Dialog

Client Name: XXXXXXXX
Date of Birth: XXXXXXXX

The client's information will be collected as:

Adult (3368)
 Child (3820)

Do you wish to create a case for this person?

Form Selection

Disability Case Process 999-99-9999 Joshua Ovard - Microsoft Internet Explorer provided by IE6.0 SP1 > AlphaCI X

Form(s) Selection - AN: 999-99-9999 CDR CEF: Y CPD CEF: NYA [Open in eView](#) [Hide Instructions](#)

Form(s) Selection

* **Form SSA-3368-BK Disability Report Adult:** Key Paper Not Yet Answered

Curtail Form Completion: Yes No

* **Form SSA-3369-BK Work History Adult:** Key Paper None

* **Do you have an appointed representative?** Yes No Not Yet Answered

About You, Part 1 of 2

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Flags/Messages

3368 About You

Identification

Name: XXXXXXXXXXXXXXXX
XXXXXXXXXXXXX
XXXXXXXXXXXXX

Daytime telephone number: XXXXXXXXXXXXXXXX
XXXXXXXXXXXXX

Please enter an alternate phone number or a phone number where a message can be left, if available.

Telephone Number is: U.S. Foreign None

Alternate telephone number:

Email Address:

Your Language Information

Can you speak and understand English? Yes No Not Yet Answered

What language do you prefer? Spanish

Can you read and understand English? Yes No Not Yet Answered

Can you write more than your name in English? Yes No Not Yet Answered

Other Names Used

How many other names or nicknames do you wish to add to your record?

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About You, Part 2 of 2

Other Names = Yes, but no other names entered

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Your Language Information

Can you speak and understand English? Yes No Not Yet Answered

What language do you prefer? Spanish

Can you read and understand English? Yes No Not Yet Answered

Can you write more than your name in English? Yes No Not Yet Answered

Other Names Used

Have you used any other names on your medical or educational records?
Examples are maiden name, other married name, or nickname.




Yes No Not Yet Answered

To add a name, choose Add. To edit, select the name below.

Other Names

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Other Names Used

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Other Names Used [Open in eView](#) [Hide Instructions](#)

Add each name that might appear on your medical or educational records.

* **First name:**

Middle name:

* **Last name:**

Suffix 

About You, Part 2 of 2

Other Names = Yes, with another name entered

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Your Language Information

Can you speak and understand English? Yes No Not Yet Answered

What language do you prefer? Spanish

Can you read and understand English? Yes No Not Yet Answered

Can you write more than your name in English? Yes No Not Yet Answered

Other Names Used

Have you used any other names on your medical or educational records?
Examples are maiden name, other married name, or nickname.

Yes No Not Yet Answered

To add a name, choose Add. To edit, select the name below.

Other Names

- [Ovard, Josh](#)

Add

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Contacts, Part 1 of 3

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3368 Contacts

Alternate Contact Information

Is there someone (other than your doctors) we can contact who knows about your medical conditions, and can help you with your case?

Yes No Not Yet Answered

Name of Alternate Contact

First name: Middle Name: Last name: Suffix:

Relationship to Disabled Person:

Address for Alternate Contact

Mailing address is: U.S. Foreign

Street address line 1:

Street address line 2:

Street address line 3:

Street address line 4:

Contacts, Part 2 of 3

Person Completing Report = Claimant

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Flags/Messages

Street address line 4:

City: **State:** -- **Zip Code:**

Telephone for Alternate Contact

Please enter an alternate phone number or a phone number where a message can be left, if available.

Telephone Number is: U.S. Foreign None

Daytime telephone number: (999-999-9999) **Ext:**

Preferred Language of Alternate Contact

Can this person speak and understand English? Yes No Not Yet Answered

Person Completing the Report

Who is providing information?

Joshua Ovard

Alternate Contact listed above

Someone else

| | |

Contacts, Part 3 of 3

Person Completing Report = Someone Else

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Someone else

*First name: Middle Name: *Last name: Suffix:

Relationship to Disabled Person:

Address for Person Completing This Report

Mailing address is: U.S. Foreign

Street address line 1:

Street address line 2:

Street address line 3:

Street address line 4:

City: State: Zip Code:

Telephone for Person Completing This Report

Telephone Number is: U.S. Foreign None

Daytime telephone number: (999-999-9999) Ext:

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Medical Conditions

Medical Conditions Propagated from mainframe, no new conditions entered

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Flags/Messages

3368 Medical Conditions

Alleged onset date from the mainframe is: 09/15/2008

Physical and Mental Conditions

*** List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.**

Enter one condition **on each line**. You will be given additional lines as needed.

1.

2.

Do your conditions cause you pain or other symptoms?

Yes No Not Yet Answered

Height and Weight

What is your height without shoes? feet: inches:

What is your weight without shoes? pounds:

| | |

Medical Conditions

Medical Conditions Propagated from mainframe, plus one new condition entered

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3368 Medical Conditions

Alleged onset date from the mainframe is: 09/15/2008

Physical and Mental Conditions

*** List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.**

Enter one condition **on each line**. You will be given additional lines as needed.

1.
2.
3.

Do your conditions cause you pain or other symptoms?

Yes No Not Yet Answered

Height and Weight

What is your height without shoes? feet: inches:

| | |

Work and Onset

Are you currently working? = Not Yet Answered

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3368 Work and Onset

Alleged onset date from the mainframe is: 09/15/2008

Are you currently working?

- No, I have never worked
- No, I have stopped working
- Yes, I am currently working
- Not Yet Answered

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Work and Onset

Claimant never worked

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3368 Work and Onset

Alleged onset date from the mainframe is: 09/15/2008

Are you currently working?

No, I have never worked

No, I have stopped working

Yes, I am currently working

Not Yet Answered

When do you believe your condition became severe enough to keep you from working (even though you have never worked) (MM/DD/YYYY)? 09/15/2008

[Where did this date come from?](#)

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Work and Onset, Part 1 of 2

Claimant stopped working because of condition(s), did not make changes in work activity before stopping work

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3368 Work and Onset

Alleged onset date from the mainframe is: 09/15/2008

Are you currently working?

No, I have never worked
 No, I have stopped working
 Yes, I am currently working
 Not Yet Answered

When did you stop working? (MM/DD/YYYY)

Why did you stop working?

Because of my condition(s).
 Because of other reasons.
 Because of my condition(s) and other reasons.
 Not Yet Answered

Did your condition(s) cause you to make changes in your work activity before you stopped working?

Yes No Not Yet Answered

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Work and Onset, Part 2 of 2

Claimant stopped working because of condition(s), did make changes in work activity before stopping work

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Flags/Messages

No, I have never worked

No, I have stopped working

Yes, I am currently working

Not Yet Answered

When did you stop working? (MM/DD/YYYY)

Why did you stop working?

Because of my condition(s).

Because of other reasons.

Because of my condition(s) and other reasons.

Not Yet Answered

Did your condition(s) cause you to make changes in your work activity before you stopped working?

Yes No Not Yet Answered

When did you make changes? (MM/DD/YYYY)

Since the date you made changes, have you had gross earnings greater than \$980 in any month? Do not count sick leave, vacation, or disability pay.

Yes No Not Yet Answered

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Work and Onset, Part 1 of 2

Claimant stopped working because of other reasons, did make changes in work activity before stopping work

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3368 Work and Onset

Alleged onset date from the mainframe is: 09/15/2008

Are you currently working?

No, I have never worked

No, I have stopped working

Yes, I am currently working

Not Yet Answered

When did you stop working? (MM/DD/YYYY)

Why did you stop working?

Because of my condition(s).

Because of other reasons.

Because of my condition(s) and other reasons.

Not Yet Answered

Please explain why you stopped working.

[Examples of stopping work](#)

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Work and Onset, Part 2 of 2

Claimant stopped working because of other reasons, did make changes in work activity before stopping work

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Because of my condition(s) and other reasons.

Not Yet Answered

Please explain why you stopped working.

[Examples of stopping work](#)

When do you believe that your condition became severe enough to keep you from returning to work (MM/DD/YYYY)?

Did your condition(s) cause you to make changes in your work activity before you stopped working?

Yes No Not Yet Answered

When did you make changes? (MM/DD/YYYY)

Since the date you made changes, have you had gross earnings greater than \$980 in any month? Do not count sick leave, vacation, or disability pay.

Yes No Not Yet Answered

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Work and Onset

Claimant is currently working, condition has caused changes in work activity

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3368 Work and Onset

Alleged onset date from the mainframe is: 09/15/2008

Are you currently working?

No, I have never worked

No, I have stopped working

Yes, I am currently working

Not Yet Answered

Has your condition caused you to make any changes in your work activity?

Yes No Not Yet Answered

When did you make changes? (MM/DD/YYYY)

Since your condition(s) first bothered you, have you had gross earnings greater than \$980 in any month? Do not count sick leave, vacation, or disability pay.

Yes No Not Yet Answered

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Work and Onset

Claimant is currently working, condition has not caused changes in work activity

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3368 Work and Onset

Alleged onset date from the mainframe is: 09/15/2008

Are you currently working?

No, I have never worked
 No, I have stopped working
 Yes, I am currently working
 Not Yet Answered

Has your condition caused you to make any changes in your work activity?

Yes No Not Yet Answered

When did your condition first start bothering you? (MM/DD/YYYY) 9/15/2008
[Where did this date come from?](#)

Since your condition(s) first bothered you, have you had gross earnings greater than \$980 in any month? Do not count sick leave, vacation, or disability pay.

Yes No Not Yet Answered

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Job History

Initial View

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3368 Job History

Alleged onset date: 09/15/2008

How many jobs did you have in the 15 years before you became unable to work because of your physical or mental conditions?

0

1

2-5

6 or more

Not Yet Answered

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Job History

No Jobs

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3368 Job History

Alleged onset date: 09/15/2008

How many jobs did you have in the 15 years before you became unable to work because of your physical or mental conditions?

0
 1
 2-5
 6 or more
 Not Yet Answered

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Job History

One Job

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3368 Job History

Alleged onset date: 09/15/2008

How many jobs did you have in the 15 years before you became unable to work because of your physical or mental conditions?

0

1

2-5

6 or more

Not Yet Answered

List the job. If you need to add more jobs, you must change your answer above.

To add a job, choose Add Job. To edit, select a job title below.

Job Title	From	To

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Job History

Two to Five Jobs

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3368 Job History

Alleged onset date: 09/15/2008

How many jobs did you have in the 15 years before you became unable to work because of your physical or mental conditions?

0

1

2-5

6 or more

Not Yet Answered

List the jobs. Start with your most recent job.

To add a job, choose Add Job. To edit, select a job title below.

Job Title	From	To

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Job History

Six or More Jobs

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3368 Job History

Alleged onset date: 09/15/2008

How many jobs did you have in the 15 years before you became unable to work because of your physical or mental conditions?

0

1

2-5

6 or more

Not Yet Answered

List the jobs. Start with your most recent job.

To add a job, choose Add Job. To edit, select a job title below.

Job Title	From	To

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Job Information

Claimant had more than one job in last 15 years before becoming unable to work

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Job Information [Open in eView](#) [Hide Instructions](#)

Occupation or job title:
Examples:
• Short order cook, not just cook
• Elementary school teacher, not just teacher
• Long-haul truck driver, not just driver

Type of Business:

Dates Worked

If you can't remember the exact dates, be as specific as possible (month or season and year). If you are currently working in this job, enter "Present" in the To: input field.

From: **To:**

Is this your most recent job? Yes No Not Yet Answered

Most Recent Hours and Pay

Average hours per day:

Average days per week:

Rate of Pay:
If you did "piece work", give the average amount you earned per day. If you were on commission, give the average amount per month.

\$ Per

Job History

User has entered five jobs

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3368 Job History

Alleged onset date: 09/15/2008

How many jobs did you have in the 15 years before you became unable to work because of your physical or mental conditions?

0

1

2-5

6 or more

Not Yet Answered

List the jobs. Start with your most recent job.




To add a job, choose Add Job. To edit, select a job title below.

Job Title	From	To
Cook	01/1985	01/1995
Waiter	01/1995	01/2000
Manager	01/2000	01/2003
Manager	01/2003	01/2005
Manager	01/2005	03/2005

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Add Job, Part 1 of 4

Claimant had only one job in last 15 years before becoming unable to work

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Job Information [Open in eView](#) [Hide Instructions](#)

Occupation or job title:
Examples:
• Short order cook, not just cook
• Elementary school teacher, not just teacher
• Long-haul truck driver, not just driver

Type of Business:

Dates Worked

If you can't remember the exact dates, be as specific as possible (month or season and year). If you are currently working in this job, enter "Present" in the To: input field.

From: **To:**


Is this your most recent job? Yes No Not Yet Answered

Most Recent Hours and Pay

Average hours per day:

Average days per week:

Rate of Pay:
If you did "piece work", give the average amount you earned per day. If you were on commission, give the average amount per month.

\$ Per 

Add Job, Part 2 of 4

Claimant had only one job in last 15 years before becoming unable to work

What did you do all day in this job?

Describe this job. What did you do all day?

In this job, did you:

Use machines, tools, or equipment?

Examples:

- Carpenters may use tools like power saws and nail guns
- Administrative assistants may use a computer

Yes No Not Yet Answered

Use technical knowledge or skills?

Examples:

- Electricians may use a computer
- Teachers know the subjects they teach

Yes No Not Yet Answered

Do any writing, complete forms, or perform duties like this?

Examples:

- Waitresses write customers' orders
- Bookkeepers complete reports
- Truck drivers complete trip logs

Yes No Not Yet Answered

Add Job, Part 3 of 4

Claimant had only one job in last 15 years before becoming unable to work

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

The following numbers do not have to add up to the total "Average hours per day" listed above because you may be performing more than one activity at a time. For example, you may be standing and lifting or sitting and typing simultaneously.

Walk?	<input type="text"/>
Stand?	<input type="text"/>
Sit?	<input type="text"/>
Climb? (stairs, ladders, etc.)	<input type="text"/>
Stoop? (bend down and forward at the waist)	<input type="text"/>
Kneel? (bend legs to rest on knees)	<input type="text"/>
Crouch? (bend legs and back down and forward)	<input type="text"/>
Crawl? (move on hands and knees)	<input type="text"/>
Handle large objects? Examples: •Lift a box •Move a lever such as a gear shift	<input type="text"/>

Add Job, Part 4 of 4

Claimant had only one job in last 15 years before becoming unable to work

Write, type, or handle small objects?

Example:

- Write on a pad
- Use a calculator
- Sort objects by hand

Reach?

Physical Activities: Lifting and Carrying

Describe what you lifted, how far you carried it, and how often you did this in your job.
[Examples of lifting and carrying](#)

Select the heaviest weight lifted:

Select the weight frequently lifted:
(By frequently, we mean from 1/3 to 2/3 of the workday.)

Did you supervise people in this job?
 Yes No Not Yet Answered

How many people did you supervise?

What part of your time did you spend supervising people?

Did you hire and fire employees? Yes No Not Yet Answered

Were you a lead worker?
 Yes No Not Yet Answered

Job History

User has entered one job

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Flags/Messages

3368 Job History

Alleged onset date: 09/15/2008

How many jobs did you have in the 15 years before you became unable to work because of your physical or mental conditions?

0

1

2-5

6 or more

Not Yet Answered

List the job. If you need to add more jobs, you must change your answer above.

To add a job, choose Add Job. To edit, select a job title below.

Job Title	From	To
Cook	01/1985	Present

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Medical Sources

Initial view

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3368 Medical Sources

Alleged Onset Date: 09/15/2008

Doctors, Therapists, Hospital, Clinics

Have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or do you have a future appointment scheduled:

* For any **physical** condition(s)
 Yes No Not Yet Answered

* For any **mental** condition(s) (including emotional or learning problems)
 Yes No Not Yet Answered

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Medical Sources

User has indicated claimant has medical sources, but has not entered any

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Flags/Messages

Alleged Onset Date: 09/15/2006

Doctors, Therapists, Hospital, Clinics

Have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or do you have a future appointment scheduled:

* For any **physical** condition(s)
 Yes No Not Yet Answered

* For any **mental** condition(s) (including emotional or learning problems)
 Yes No Not Yet Answered

Tell us who may have medical records about any of your **physical or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals (**including emergency room visits**), clinics, and other health care facilities.




Tell us about your **next appointment**, if you have one scheduled.

To add a health care provider, choose Add Doctor/Hospital/Etc. To edit, select the name below.

Name	Address

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Doctor/Therapist Information, Part 1 of 2

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Doctor/Therapist Information Source to Merge

Alleged onset date: 09/15/2008

Name: XXXXXXXXXX

Attention:

Address: 147 West 400 North

Patient ID# (if known):

Dates

First visit:

Last visit:

Next appointment:

Conditions and Treatments

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions?

Doctor/Therapist Information, Part 2 of 2

Tests

List any tests **this provider** performed, sent you to, or scheduled you to take in the future.

To add a test, choose Add Test. To edit, select the name of the test below.

Test	Date	Ordered By

Add Test

Medicines

List all medicines prescribed or suggested **by this provider**.

To add a medicine, choose Add Medicine. To edit, select the name of the medicine below.

Medicine	Prescribed By	Reason

Add Medicine

Physical and Mental Conditions

List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

To add a condition, choose Add Condition. To edit, select the name of the condition below.

Name
Fatigue, Fibromyalgia
Migraines

Add or Edit Conditions

OK

Delete

Add Another Source

Cancel

Help

Medical Sources

User has indicated claimant has medical sources and entered a doctor

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3368 Medical Sources

Alleged Onset Date: 09/15/2008

Doctors, Therapists, Hospital, Clinics

Have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or do you have a future appointment scheduled:

* For any **physical** condition(s)
 Yes No Not Yet Answered

* For any **mental** condition(s) (including emotional or learning problems)
 Yes No Not Yet Answered

Tell us who may have medical records about any of your **physical or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals (**including emergency room visits**), clinics, and other health care facilities.

Tell us about your **next appointment**, if you have one scheduled.

To add a health care provider, choose Add Doctor/Hospital/Etc. To edit, select the name below.

Name	Address
Dr. John McKell	147 West 400 North

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Hospital/Clinic Information, Part 1 of 3

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Hospital/Clinic Information

Alleged onset date: 09/15/2008

Name of facility or office: [Utah General Hospital](#)

Attention:

Address: 6701 Main Street

Health care professional who treated you at Utah General Hospital:

Patient ID# (if known):

Dates at this Facility

Did you have any inpatient stays? Yes No Not Yet Answered

Date In:	<input type="text"/>	Date Out:	<input type="text"/>
Date In:	<input type="text"/>	Date Out:	<input type="text"/>
Date In:	<input type="text"/>	Date Out:	<input type="text"/>

Did you have any outpatient visits? Yes No Not Yet Answered

First visit:

Last visit:

Next appointment:

Hospital/Clinic Information, Part 2 of 3

Did you have any emergency room visits?



Yes



No



Not Yet Answered

Date of visit:

Date of visit:

Date of visit:

Conditions and Treatments

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions?

Tests

List any tests **this provider** performed, sent you to, or scheduled you to take in the future.

To add a test, choose Add Test. To edit, select the name of the test below.

Test	Date	Ordered By

Add Test

Hospital/Clinic Information, Part 3 of 3

Medicines

List all medicines prescribed or suggested by **this provider**.

To add a medicine, choose Add Medicine. To edit, select the name of the medicine below.

Medicine	Prescribed By	Reason

Add Medicine

Physical and Mental Conditions

List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

To add a condition, choose Add Condition. To edit, select the name of the condition below.

Name
Fatigue, Fibromyalgia
Migraines

Add or Edit Conditions

OK

Delete

Add Another Source

Cancel

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Tests Summary

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Flags/Messages

3368 Tests Summary

Have you had any medical tests, or do you have any tests scheduled for your condition?

Yes No Not Yet Answered

List all tests that you had or will have for your condition.

To add a test, choose Add Test. To edit, select the name of the test below.

Test	Date	Ordered By
X-Ray	12/16/2008	Dr. John McKell

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Test Information

No body part involved

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Test Information [Open in eView](#) [Hide Instructions](#)

***Name of Test:**

Date of Test:

Provider who performed, sent you to, or scheduled you to take this test.
If you need to add a medical source, you must return to MED SOURCES.

Physical and Mental Conditions

List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

To add or edit a condition, choose Add or Edit Conditions.

Name
Fatigue, Fibromyalgia
Migraines

Test Information

Body part involved

Disability Case Process 123-45-6789 Joshua Ovard - Microsoft Internet Explorer provided by IE6.0 SP1...

Test Information [Open in eView](#) [Hide Instructions](#)

*Name of Test:

What part of your body was covered or will be covered by this test?

Date of Test:

Provider who performed, sent you to, or scheduled you to take this test.
If you need to add a medical source, you must return to MED SOURCES.

Physical and Mental Conditions

List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

To add or edit a condition, choose Add or Edit Conditions.

Name
Fatigue, Fibromyalgia
Migraines

Physical and Mental Condition Information – Plan A

Claimant adds physical or mental condition while adding test

Disability Case Process 123-45-6789 Joshua Ovard - Microsoft Internet Explorer provided by IE6.0 SP1...

Physical and Mental Condition Information [Open in eView](#) [Hide Instructions](#)

Enter one condition on each line. You will be given additional lines as needed.

1.

2.

3.

Physical and Mental Condition Information – Plan B

Claimant adds physical or mental condition while adding test

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Physical and Mental Condition Information [Open in eView](#) [Hide Instructions](#)

***Enter a physical and/or mental condition (including emotional or learning problems) that limits your ability to work.**

Medicines Summary

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3368 Medicines Summary

Are you taking any prescription or non-prescription medicines?

Yes No Not Yet Answered

List all prescription and non-prescription medicines that you take for your condition.

To add a medicine, choose Add. To edit, select the medicine listed below.

Medicine	Prescribed By	Reason
Ambien	Dr. John McKell	Insomnia

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Medicine Information

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Medicine Information [Open in eView](#) [Hide Instructions](#)

***Name of Medicine:**

Who prescribed this medicine (if prescription):
If you need to add a medical source, you must return to MED SOURCES.

Reason for medicine:
Examples:
• Slows down my heart rate
• Regulates my blood sugar
• Stops the pain

Physical and Mental Conditions
List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.
To add or edit a condition, choose Add or Edit Conditions.

Name
Fatigue, Fibromyalgia
Migraines
Muscle pain

Other Medical Information

Initial View

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3368 Other Medical Information

Does anyone else have medical information about your physical or mental condition(s) (including emotional and learning problems), or are you scheduled to see anyone else?

Examples:

- Workers' Compensation
- Vocational rehabilitation
- Insurance companies who have paid you disability benefits
- Prisons
- Attorneys
- Welfare or social service agency

Yes No Not Yet Answered

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Other Medical Information

User has indicated claimant has other medical source, but has not entered any

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3368 Other Medical Information

Does anyone else have medical information about your physical or mental condition(s) (including emotional and learning problems), or are you scheduled to see anyone else?

Examples:

- Workers' Compensation
- Vocational rehabilitation
- Insurance companies who have paid you disability benefits
- Prisons
- Attorneys
- Welfare or social service agency

Yes No Not Yet Answered

To add a medical source, choose Add Another. To edit, select the name below.

Name	Address

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Other Medical Information

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Other Medical Information [Open in eView](#) [Hide Instructions](#)

Alleged Onset Date: 9/15/2008

Name:
Attn:
Address:

Claim or ID Number, if any:

Dates

Date of first contact:
Date of last contact:
Date of next contact, if any:

Reasons for Contacts

Reasons for contacts:

Physical and Mental Conditions

List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.
To add or edit a condition, choose Add or Edit Conditions.

Name
Fatigue, Fibromyalgia
Migraines
Muscle pain

Other Medical Information

User has entered an other medical source

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3368 Other Medical Information

Does anyone else have medical information about your physical or mental condition(s) (including emotional and learning problems), or are you scheduled to see anyone else?

Examples:

- Workers' Compensation
- Vocational rehabilitation
- Insurance companies who have paid you disability benefits
- Prisons
- Attorneys
- Welfare or social service agency

Yes No Not Yet Answered

To add a medical source, choose Add Another. To edit, select the name below.

Name	Address
CoreSource	PO Box 2920, Clinton, IA

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Education and Training

Initial View

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3368 Education and Training

Alleged onset date: 09/15/2008

What is the highest grade of school that you completed?

Approximate date completed:

Special Education

Did you attend special education classes?

[Examples](#)

Yes No Not Yet Answered

Job Training or Vocational School

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

[Examples](#)

Yes No Not Yet Answered

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Education and Training, Part 1 of 2

User has indicated claimant received special education and job training/vocational school, but has not entered any

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Flags/Messages

3368 Education and Training

Alleged onset date: 09/15/2008

What is the highest grade of school that you completed?

Approximate date completed:

Special Education

Did you attend special education classes?
[Examples](#)
 Yes No Not Yet Answered

List all schools where you attended special education classes.
To add a school, choose Add. To edit, select the school below.

Name	Address

Job Training or Vocational School

| | |

Education and Training, Part 2 of 2

User has indicated claimant received special education and job training/vocational school, but has not entered any

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Flags/Messages

List all schools where you attended special education classes.

To add a school, choose Add. To edit, select the school below.

Name	Address

Add

Job Training or Vocational School

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

[Examples](#)

Yes No Not Yet Answered

Describe the types of vocational programs attended.

Approximate date completed:

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Special Education Information

Initial View

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Special Education Information [Open in eView](#) [Hide Instructions](#)

Alleged Onset Date: 9/15/2008

Name:
Attn:
Address:

Dates Attended

If you can't remember the exact dates, be as specific as possible.
Examples:

- June 10, 2001
- February 1998
- Summer 1995

From: **To:**

Physical and Mental Conditions

List all physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work.

To add or edit a condition, choose Add or Edit Conditions.

Name
Fatigue, Fibromyalgia
Migraines
Muscle pain

Special Education Information

User has entered a school

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3368 Education and Training

Alleged onset date: 09/15/2008

What is the highest grade of school that you completed?

Approximate date completed:

Special Education

Did you attend special education classes?

[Examples](#)

Yes No Not Yet Answered

List all schools where you attended special education classes.

To add a school, choose Add. To edit, select the school below.

Name	Address
Provo Academy	100 West 50th Street South

Job Training or Vocational School

| | |

Remarks

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3368 Remarks

Please provide any additional information you did not give in earlier parts of this report.

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