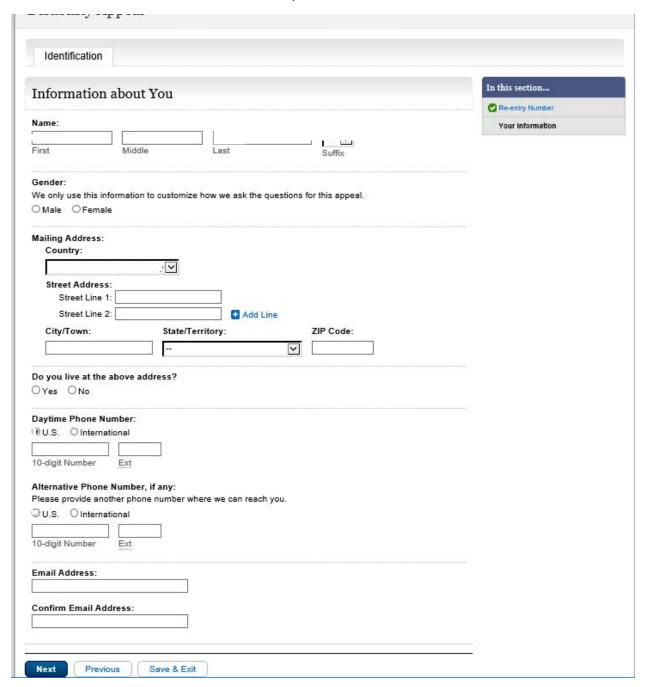
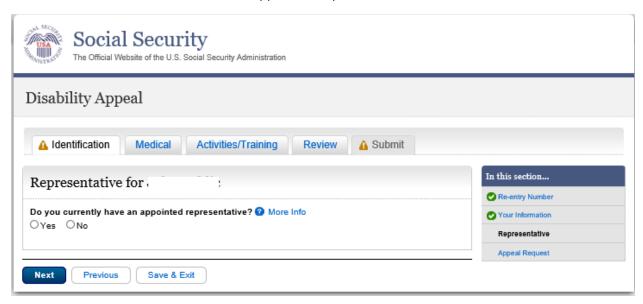
13441 Screenshots for Claimant and Third party

Claimant

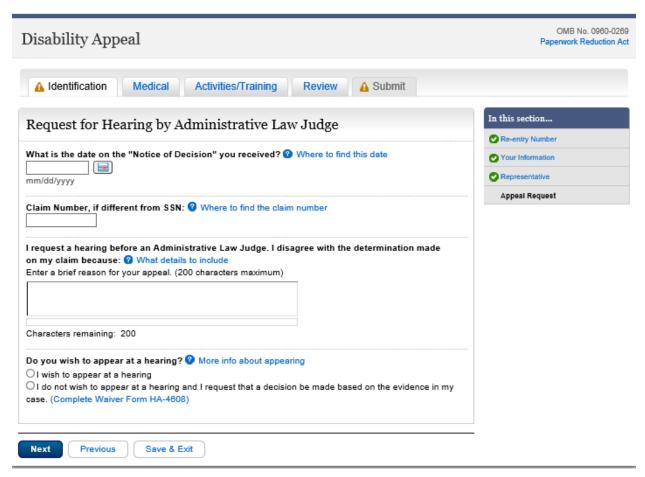
About you



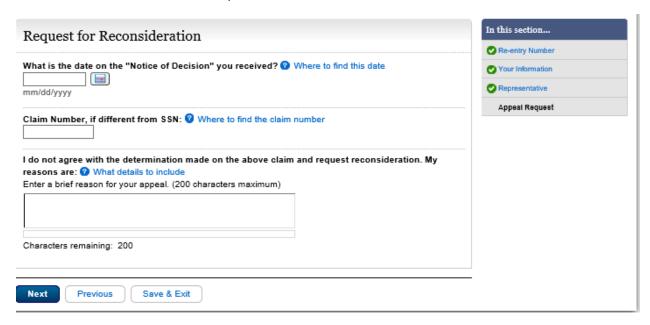
Appointed Rep



Request for Hearing



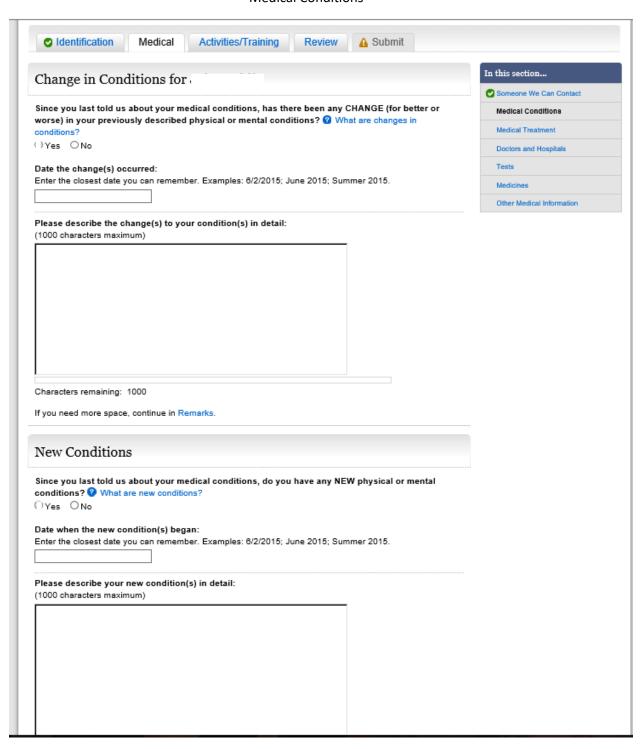
Request for Reconsideration



Contacts

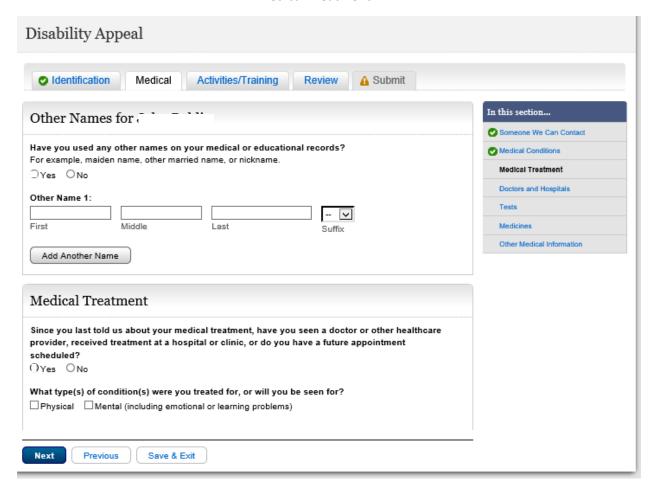


Medical Conditions

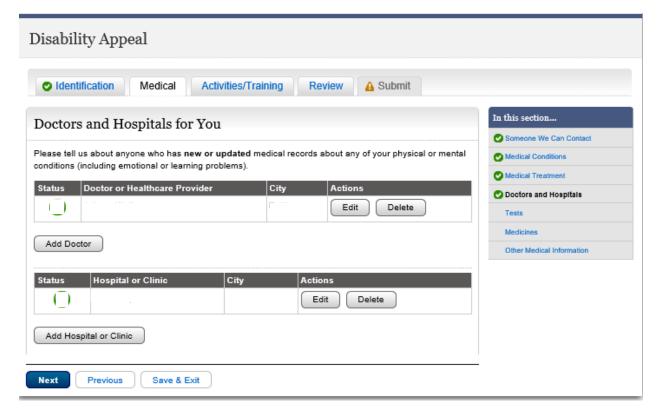


Characters remaining: 1000	
If you need more space, continue in Remarks.	
New Conditions	
Since you last told us about your medical conditions, do you have any Ne conditions? ○ What are new conditions? ○ Yes ○ No	W physical or mental
Date when the new condition(s) began: Enter the closest date you can remember. Examples: 6/2/2015; June 2015; Su	nmer 2015.
Please describe your new condition(s) in detail: (1000 characters maximum)	
Characters remaining: 1000 If you need more space, continue in Remarks.	
n you need more space, continue in remarks.	
Next Previous Save & Exit	

Medical Treatment



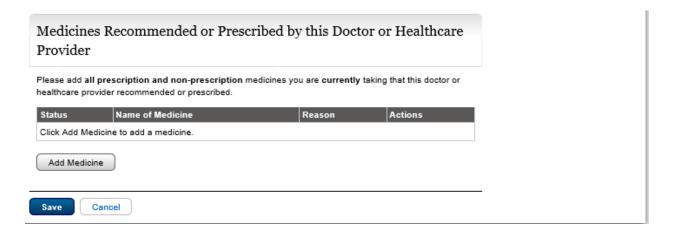
Doctors and Hospitals



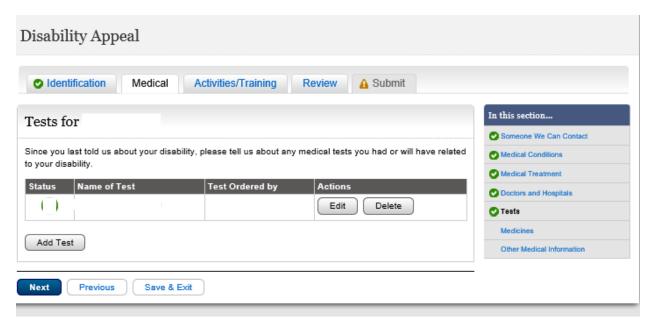
Doctor or Healthcare Providers

Doctor or Healthcare Provider Details
Name of Doctor or Healthcare Provider: Title First Last Suffix
Name of Practice or Medical Group:
Phone Number: U.S. O International 10-digit Number Ext
Address: Country: Street Address: Street Line 1: Street Line 2: City/Town: State/Territory: ZIP Code: Patient ID Number, if known:
Treatment Dates with this Doctor or Healthcare Provider
Enter the closest date(s) you can remember. Examples: 6/2/2015; June 2015; Summer 2015. First Visit:
Last Visit:
Next Scheduled Appointment, if any:

	Medical Conditions Treated by this Doctor or Healthcare Provider
	What medical conditions were treated or evaluated? Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)
_	Characters remaining: 1000
,	Treatment from this Doctor or Healthcare Provider
	What treatment did you receive for the above conditions? You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum) Characters remaining: 1000
	Tests Ordered by this Doctor or Healthcare Provider
	Please add any tests this doctor or healthcare provider ordered for you, including those scheduled in the future. You will have another opportunity to provide this information.
	Status Name of Test Actions Click Add Test to add a test.
1	Add Test
- 1	



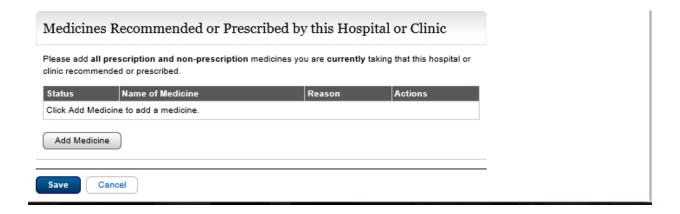
Tests



Hospitals or Clinic Details

Add Line City/Town: State/Territory: City/Town: State/Territory: Add Line City/Town: State/Territory: ZIP Code:	ame of Hospital	
hone Number: OU.S. O International O-digit Number Ext ddress: Country: Street Address: Street Line 1: Street Line 2: City/Town: State/Territory: ZIP Code:		or Clinic:
O-digit Number Ext Address: Country: Street Address: Street Line 1: Street Line 2: City/Town: State/Territory: ZIP Code:		
O-digit Number Ext Address: Country: Street Address: Street Line 1: Street Line 2: City/Town: State/Territory: ZIP Code:	ame of Healthcar	e Provider who treated you, if known:
O-digit Number Ext Address: Country: Street Address: Street Line 1: Street Line 2: City/Town: State/Territory: ZIP Code:		
Address: Country: Street Address: Street Line 1: Street Line 2: City/Town: State/Territory: ZIP Code: Patient ID Number, if known: Patient ID Number, if known: City you can remember. Examples: 6/2/2015; June 2015; Summer 2015. Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled? Outpatient visit means you went home the same day. This does not include emergency room visits. O'Yes O No Did you have any emergency room (ER) visits at this hospital or clinic? ER visit means you went to the ER and then went home. O'Yes O No	hone Number:	
Address: Country: Street Address: Street Line 1: Street Line 2: City/Town: State/Territory: ZIP Code:	U.S. O Internat	tional
Address: Country: Street Address: Street Line 1: Street Line 2: City/Town: State/Territory: ZIP Code:		
Street Address: Street Line 1: Street Line 2: City/Town: State/Territory: ZIP Code:)-digit Number	Ext
Street Address: Street Line 1: Street Line 2: City/Town: State/Territory: ZIP Code:	ddress:	
Street Line 1: Street Line 2: City/Town: State/Territory: ZIP Code: Patient ID Number, if known: Treatment Dates at this Hospital or Clinic Enter the closest date(s) you can remember. Examples: 8/2/2015; June 2015; Summer 2015. Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled? Dutpatient visit means you went home the same day. This does not include emergency room visits. Yes ONo Did you have any emergency room (ER) visits at this hospital or clinic? ER visit means you went to the ER and then went home. Yes ONo		
Street Line 1: Street Line 2: City/Town: State/Territory: ZIP Code:		. 🔻
Street Line 2: City/Town: State/Territory: ZIP Code: Patient ID Number, if known: Treatment Dates at this Hospital or Clinic Enter the closest date(s) you can remember. Examples: 8/2/2015; June 2015; Summer 2015. Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled? Dutpatient visit means you went home the same day. This does not include emergency room visits. Yes ONo Did you have any emergency room (ER) visits at this hospital or clinic? ER visit means you went to the ER and then went home. Yes ONo	Street Address	
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Patient ID Number, if known: Treatment Dates at this Hospital or Clinic Enter the closest date(s) you can remember. Examples: 8/2/2015; June 2015; Summer 2015. Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled? Dutpatient visit means you went home the same day. This does not include emergency room visits. O'Yes O No Did you have any emergency room (ER) visits at this hospital or clinic? ER visit means you went to the ER and then went home. O'Yes O No	Street Line 2	. ■ Add Line
Patient ID Number, if known: Treatment Dates at this Hospital or Clinic Enter the closest date(s) you can remember. Examples: 8/2/2015; June 2015; Summer 2015. Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled? Outpatient visit means you went home the same day. This does not include emergency room visits. Yes ONo Did you have any emergency room (ER) visits at this hospital or clinic? ER visit means you went to the ER and then went home. Yes ONo	City/Town:	State/Territory: ZIP Code:
Treatment Dates at this Hospital or Clinic Enter the closest date(s) you can remember. Examples: 8/2/2015; June 2015; Summer 2015. Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled? Dutpatient visit means you went home the same day. This does not include emergency room visits. Yes ONo Did you have any emergency room (ER) visits at this hospital or clinic? ER visit means you went to the ER and then went home. Yes ONo		V
Freatment Dates at this Hospital or Clinic Enter the closest date(s) you can remember. Examples: 8/2/2015; June 2015; Summer 2015. Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled? Dutpatient visit means you went home the same day. This does not include emergency room visits. O'Yes ONO Did you have any emergency room (ER) visits at this hospital or clinic? ER visit means you went to the ER and then went home. O'Yes ONO		
Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled? Dutpatient visit means you went home the same day. This does not include emergency room visits. Yes ONo Did you have any emergency room (ER) visits at this hospital or clinic? ER visit means you went to the ER and then went home.	atient ID Number	, if known:
Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled? Dutpatient visit means you went home the same day. This does not include emergency room visits. Yes ONo Did you have any emergency room (ER) visits at this hospital or clinic? ER visit means you went to the ER and then went home.		
Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled? Dutpatient visit means you went home the same day. This does not include emergency room visits. Order on No Did you have any emergency room (ER) visits at this hospital or clinic? ER visit means you went to the ER and then went home.		
Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled? Dutpatient visit means you went home the same day. This does not include emergency room visits. Order ONO Did you have any emergency room (ER) visits at this hospital or clinic? ER visit means you went to the ER and then went home.	D	oten etable II emitel en Clinia
Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled? Dutpatient visit means you went home the same day. This does not include emergency room visits. Yes ONo Did you have any emergency room (ER) visits at this hospital or clinic? ER visit means you went to the ER and then went home. Yes ONo	reatment i	-
Outpatient visit means you went home the same day. This does not include emergency room visits. OYes ONo Did you have any emergency room (ER) visits at this hospital or clinic? ER visit means you went to the ER and then went home. OYes ONo		rte(s) you can remember. Examples: 6/2/2015; June 2015; Summer 2015.
Outpatient visit means you went home the same day. This does not include emergency room visits. Yes ONo Did you have any emergency room (ER) visits at this hospital or clinic? ER visit means you went to the ER and then went home. Yes ONo		
Did you have any emergency room (ER) visits at this hospital or clinic? ER visit means you went to the ER and then went home. Yes ONo	nter the closest da	outpatient visits at this hospital or clinic or do you have any scheduled?
ER visit means you went to the ER and then went home. Yes ONo	nter the closest ds	
ER visit means you went to the ER and then went home. Yes ONo	nter the closest da id you have any o utpatient visit mea	
OYes ONo	nter the closest da id you have any o utpatient visit mea	
	id you have any outpatient visit mes	ens you went home the same day. This does not include emergency room visits. emergency room (ER) visits at this hospital or clinic?
Did you have an overnight stay at this hospital or clinic?	id you have any outpatient visit mes O'Yes O No id you have any outpatient visit mes O'Yes O No	ens you went home the same day. This does not include emergency room visits. emergency room (ER) visits at this hospital or clinic?
	id you have any outpatient visit mes O'Yes O No id you have any outpatient visit mes O'Yes O No	ens you went home the same day. This does not include emergency room visits. emergency room (ER) visits at this hospital or clinic?

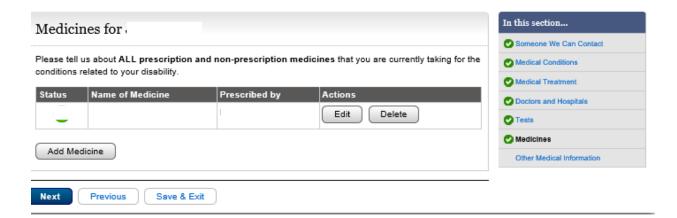
Medical Conditions Treated by this Hospital or Cl	inic
What medical conditions were treated or evaluated by this hospital or of examples: back injury, arthritis, diabetes, depression, blindness. (1000 chara	
Sharenday consision: 4000	
Characters remaining: 1000	
Treatment from this Hospital or Clinic	
You DO NOT need to include medicines and tests in this answer. Examples egular evaluations, check ups, physical therapy, chemotherapy, counseling. naximum)	
Tests Ordered at this Hospital or Clinic	
Please add any tests this hospital or clinic ordered for you, including those season another opportunity to provide this information.	cheduled in the future. You will
Status Name of Test Click Add Test to add a test.	Actions
Add Test	



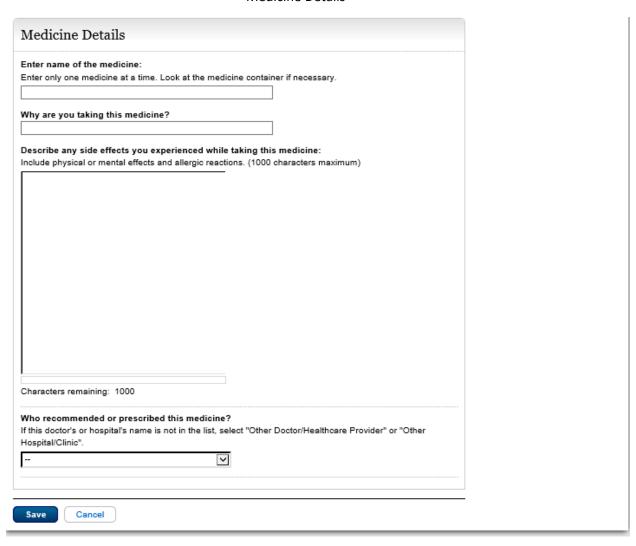
Test Details



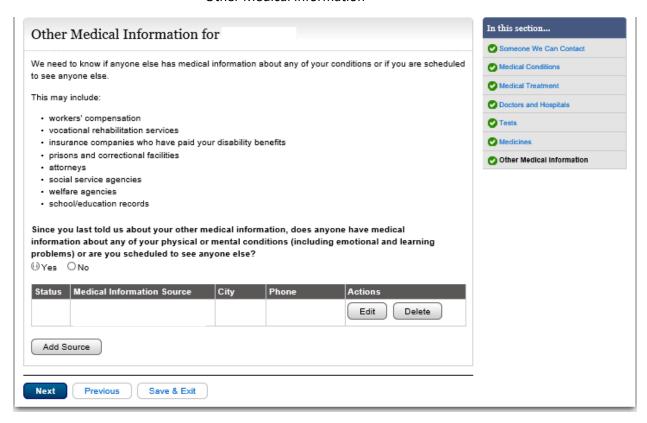
Medicines, Medical



Medicine Details



Other Medical Information



Details of Other Medical Information

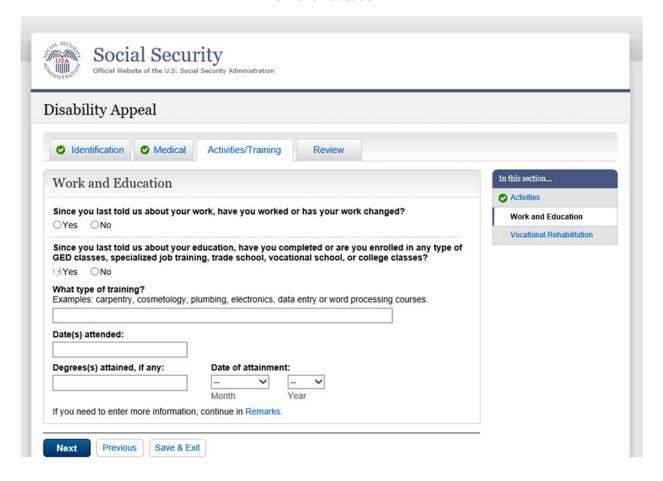
Details of Other	Medical Information		
Name of Organization:			
Claim or ID Number, if a	ny:		
Address: Country:	.\ <u>\</u>		
Street Address: Street Line 1:)[V]]	
Street Line 2:	State/Territory:	ZIP Code:	
Name of Contact Persor			
Phone Number: U.S. International 10-digit Number Ext			
	_	r/clinic in prison, or school counselor. Enter the une 2015; Summer 2015.	ie
Date of First Contact:			
Date of Last Contact:			
Date of Next Contact, if	any:		

Phone Number:
○ U.S. O International
10-digit Number Ext
Contacts with this Organization
Examples: visits to workers' compensation attorney, doctor/clinic in prison, or school counselor. Enter the
closest date(s) you can remember. Examples: 6/2/2015; June 2015; Summer 2015.
Date of First Contact:
Date of Last Contact:
Date of Next Contact, if any:
Date of Next Contact, if any.
Reasons for Contact:
(1000 characters maximum)
Characters remaining: 1000
If you need more space, continue in Remarks.
Save

Activities

Activities for	In this section
	Activities
Since you last told us about your activities, has there been any change (for better or for worse) in your daily activities due to your physical or mental conditions?	Work and Education
Examples of daily activities are household tasks, personal care, getting around, hobbies and interests,	Vocational Rehabilitation
social activities, etc.	
Please describe the changes in your daily activities in detail: (1000 characters maximum)	
Characters remaining: 1000	
If you need more space, continue in Remarks.	
Next Previous Save & Exit	

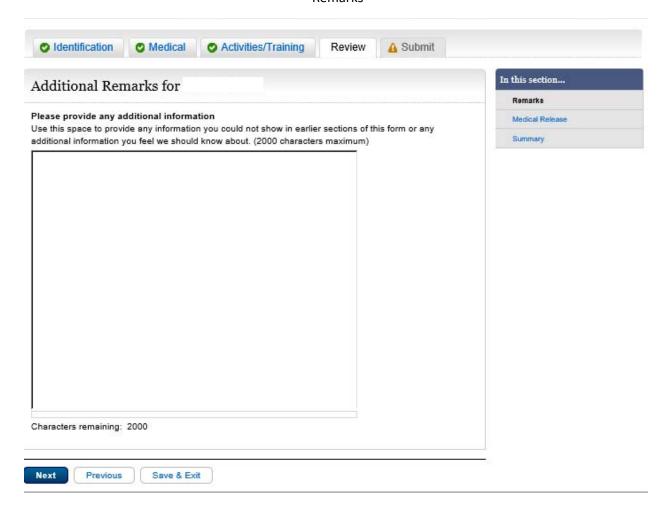
Work and Education



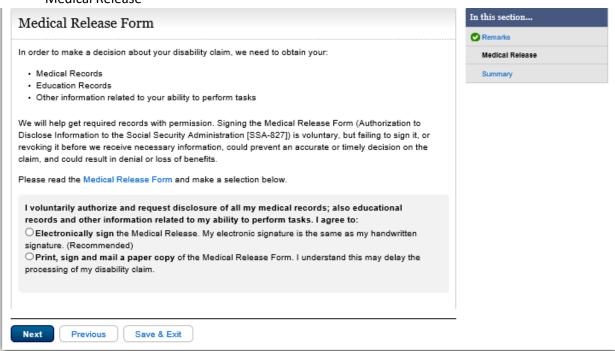
Voc Rehab

In this section... Vocational Rehabilitation, Employment, or Other Support Services for Activities Work and Education We need to know about your participation in: Vocational Rehabilitation · 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 · any program providing vocational rehabilitation, employment services, or other support services to · a Plan to Achieve Self-Support (PASS) an individualized education program (IEP) through an educational institution (if a student age 18-21) Since you last told us about your vocational rehabilitation, have you participated, or are you participating, in one of these programs? OYes ONo Name of Organization or School: Name of Counselor, Instructor, or Job Coach: Phone Number: U.S. O International 10-digit Number Address: Country: Street Address: Street Line 1: Street Line 2: 4 Add Line City/Town: ZIP Code: State: Date when you started participating in the plan or program: If you need to enter more information, continue in Remarks. Previous Save & Exit Next

Remarks

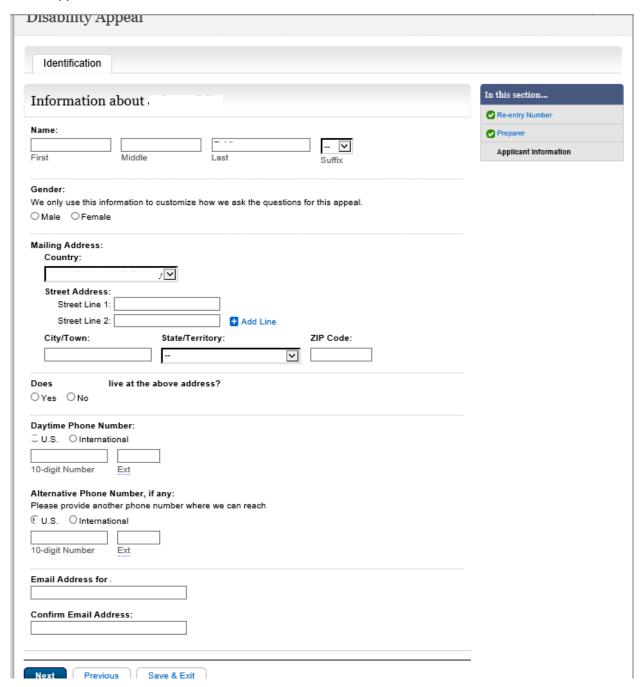


Medical Release

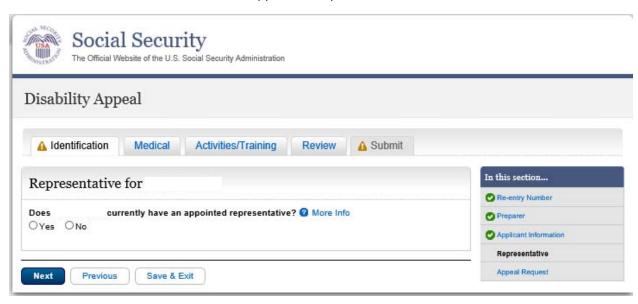


3rd Party

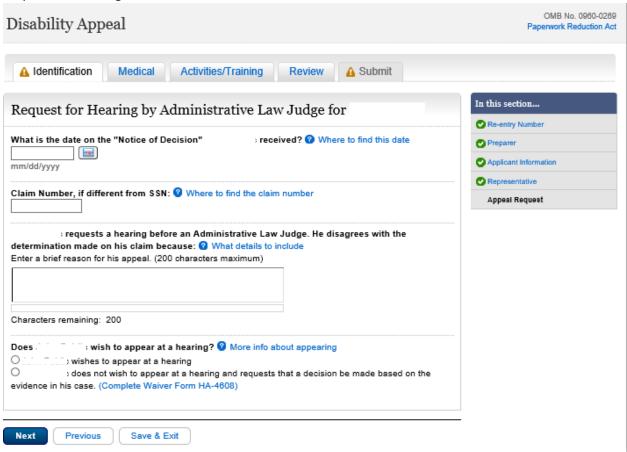
About Applicant



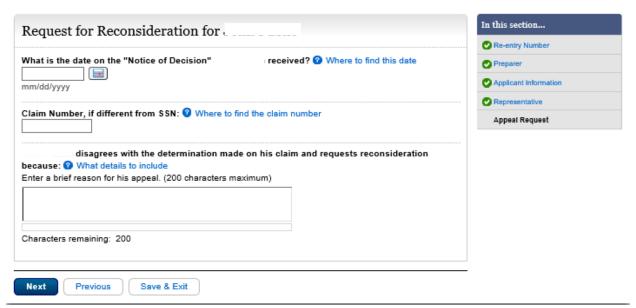
Appointed Rep



Request for Hearing



Request for Reconsideration



Contacts

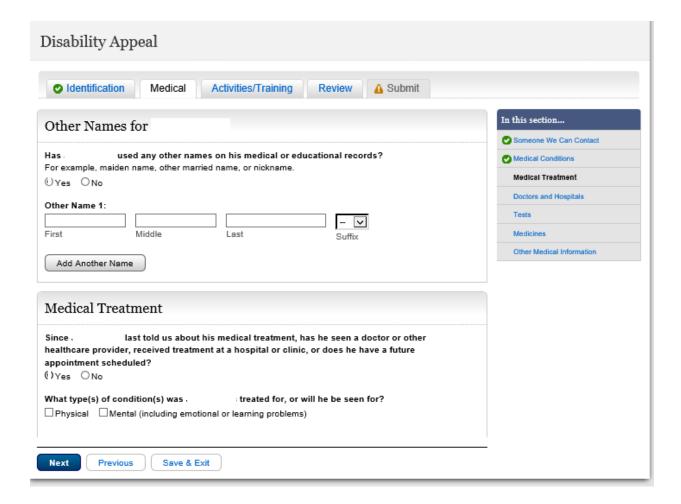


Medical Conditions

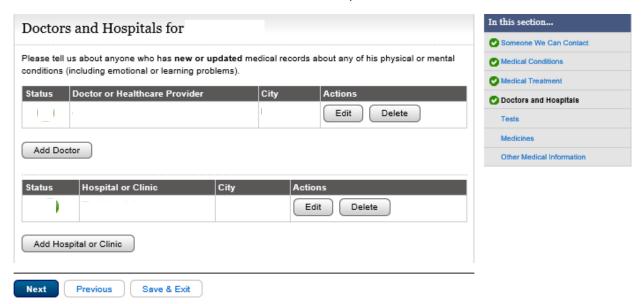
Change in Conditions for	In this section
	Someone We Can Contac
Since . : last told us about his medical conditions, has there been any CHANGE (for setter or worse) in his previously described physical or mental conditions? What are changes	Medical Conditions
n conditions?	Medical Treatment
Yes ONo	Doctors and Hospitals
Date the change(s) occurred:	Tests
Enter the closest date you can remember. Examples: 6/2/2015; June 2015; Summer 2015.	Medicines
	Other Medical Information
Characters remaining: 1000 f you need more space, continue in Remarks.	
N N N N N N N N N N N N N N N N N N N	
f you need more space, continue in Remarks.	
New Conditions Since : last told us about his medical conditions, does he have any NEW physical or nental conditions? What are new conditions?	



Medical Treatment



Doctors and Hospitals



Doctors or Healthcare Provider Details

Doctor or Healthcare Provider Details
Name of Doctor or Healthcare Provider:
lame of Practice or Medical Group:
Phone Number: U.S. O International O-digit Number Ext
Address: Country:
Freatment Dates with this Doctor or Healthcare Provider Enter the closest date(s) can remember. Examples: 8/2/2015; June 2015; Summer 2015.
First Visit:
.ast Visit:
lext Scheduled Appointment, if any:

What medical conditions were treated or evaluated?	
Examples: back injury, arthritis, diabetes, depression, blindness.	. (1000 characters maximum)
Characters remaining: 1000	
Treatment from this Doctor or Healthcare	e Provider
What treatment did receive for the above condit	
You DO NOT need to include medicines and tests in this answer	 Examples of treatment: examinations,
regular evaluations, check ups, physical therapy, chemotherapy,	-
regular evaluations, check ups, physical therapy, chemotherapy,	-
regular evaluations, check ups, physical therapy, chemotherapy,	-
regular evaluations, check ups, physical therapy, chemotherapy,	-
regular evaluations, check ups, physical therapy, chemotherapy,	-
regular evaluations, check ups, physical therapy, chemotherapy,	-
regular evaluations, check ups, physical therapy, chemotherapy,	-
regular evaluations, check ups, physical therapy, chemotherapy,	-
regular evaluations, check ups, physical therapy, chemotherapy,	-
regular evaluations, check ups, physical therapy, chemotherapy,	-
regular evaluations, check ups, physical therapy, chemotherapy, maximum)	-
regular evaluations, check ups, physical therapy, chemotherapy, maximum)	-
regular evaluations, check ups, physical therapy, chemotherapy, maximum) Characters remaining: 1000	, counseling. (1000 characters
regular evaluations, check ups, physical therapy, chemotherapy, maximum) Characters remaining: 1000	, counseling. (1000 characters
regular evaluations, check ups, physical therapy, chemotherapy, maximum) Characters remaining: 1000 Tests Ordered by this Doctor or Healthcan	re Provider
regular evaluations, check ups, physical therapy, chemotherapy, maximum) Characters remaining: 1000 Tests Ordered by this Doctor or Healthcar Please add any tests this doctor or healthcare provider ordered the future. You will have another opportunity to provide this information.	re Provider
regular evaluations, check ups, physical therapy, chemotherapy, maximum) Characters remaining: 1000 Tests Ordered by this Doctor or Healthcan	re Provider
regular evaluations, check ups, physical therapy, chemotherapy, maximum) Characters remaining: 1000 Tests Ordered by this Doctor or Healthcar Please add any tests this doctor or healthcare provider ordered the future. You will have another opportunity to provide this information.	re Provider for including those scheduled mation.
regular evaluations, check ups, physical therapy, chemotherapy, maximum) Characters remaining: 1000 Tests Ordered by this Doctor or Healthcan please add any tests this doctor or healthcare provider ordered the future. You will have another opportunity to provide this information.	re Provider for including those scheduled mation.

Hospitals or Clinic Details

Hospital or Clinic Details
Name of Hospital or Clinic:
Name of Healthcare Provider who treated John Public, if known:
Phone Number: U.S. O International 10-digit Number Ext
Address: Country: Street Address: Street Line 1: Street Line 2: City/Town: State/Territory: ZIP Code:
Patient ID Number, if known:
Treatment Dates at this Hospital or Clinic Enter the closest date(s) . ; can remember. Examples: 8/2/2015; June 2015; Summer 2015.
Did . have any outpatient visits at this hospital or clinic, or does he have any scheduled? Outpatient visit means he went home the same day. This does not include emergency room visits.
First outpatient visit: Last outpatient visit:
Next scheduled outpatient visit (if any):

Did have any er	mergency room (ER) visits at this hospital or clinic? ER and then went home.
⊕Yes ○No	
Please give the dates of	most recent emergency room visits.
Emergency Room Visit 1:	
Emergency Room Visit 2:	
Emergency Room Visit 3:	
Did have an over (i) Yes O No	ernight stay at this hospital or clinic?
VYYES ONO	
Give us the dates of John Put	olic's three most recent stays.
Visit 1:	
Date In	Date Out
V:-:4.0-	
Visit 2:	
Date In	Date Out
Visit 3:	
D-t- I-	B-t- 0-t
Date In	Date Out
Medical Conditions	Treated by this Hospital or Clinic
	ere treated or evaluated by this hospital or clinic? s, diabetes, depression, blindness. (1000 characters maximum)
Examples, back injury, armini	s, dispetes, depression, billioness. (1000 characters maximum)
Characters remaining: 1000	

Treatment from this Hospital or Clinic
What treatment did . receive for the above conditions at this hospital or clinic? You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)
Characters remaining: 1000
Tests Ordered at this Hospital or Clinic
Please add any tests this hospital or clinic ordered for , including those scheduled in the future. You will have another opportunity to provide this information.
Status Name of Test Actions Click Add Test to add a test.
Add Test
Medicines Recommended or Prescribed by this Hospital or Clinic
Please add all prescription and non-prescription medicines , is currently taking that this hospital or clinic recommended or prescribed.
Status Name of Medicine Reason Actions Click Add Medicine to add a medicine.
Add Medicine
Save

Tests

Disability Appeal Identification Medical Activities/Training Review ∆ Submit In this section... Tests for Someone We Can Contact Since you last told us about your disability, please tell us about any medical tests had or will Medical Conditions have related to his disability. Medical Treatment Status Name of Test Test Ordered by ODoctors and Hospitals Edit Delete

O Tests

Other Medical Information

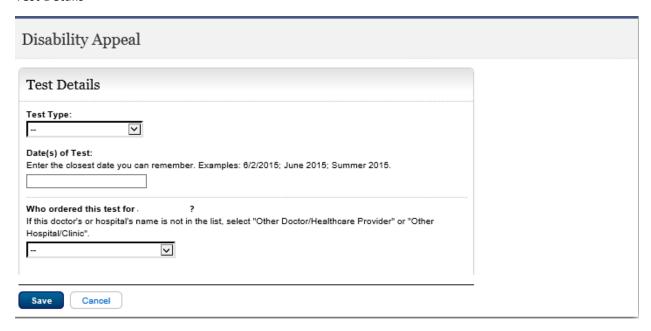
Test Details

Next

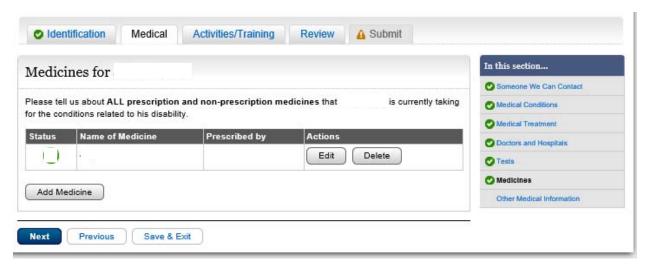
Add Test

Previous

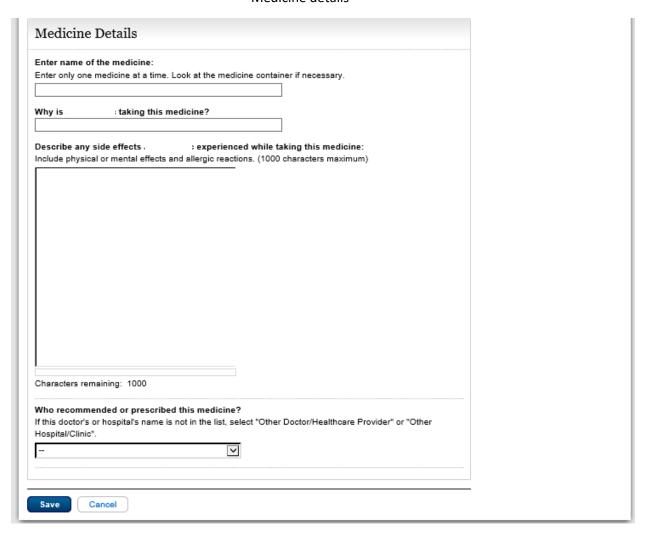
Save & Exit



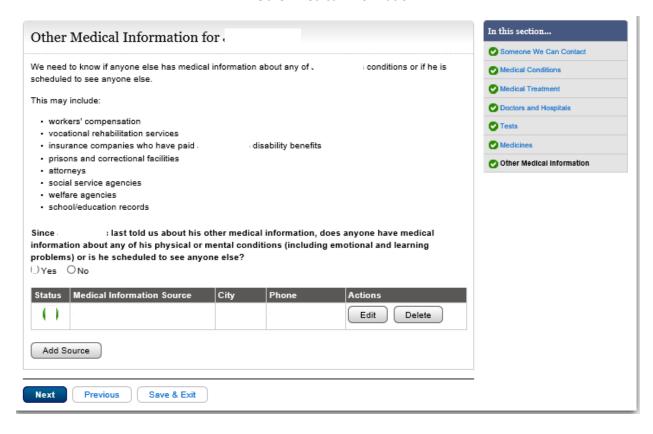
Medicines/Medical



Medicine details



Other Medical Information

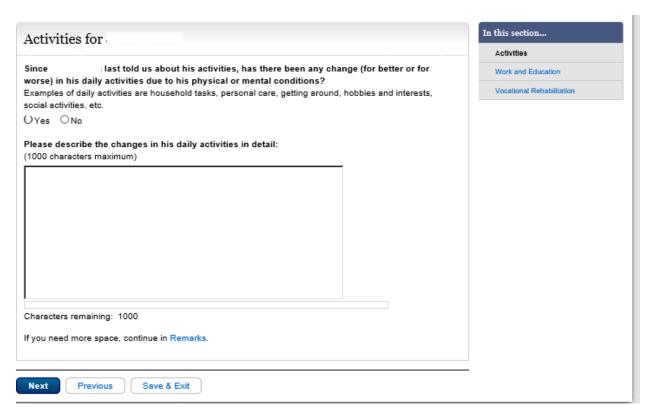


Details of Other Medical Information

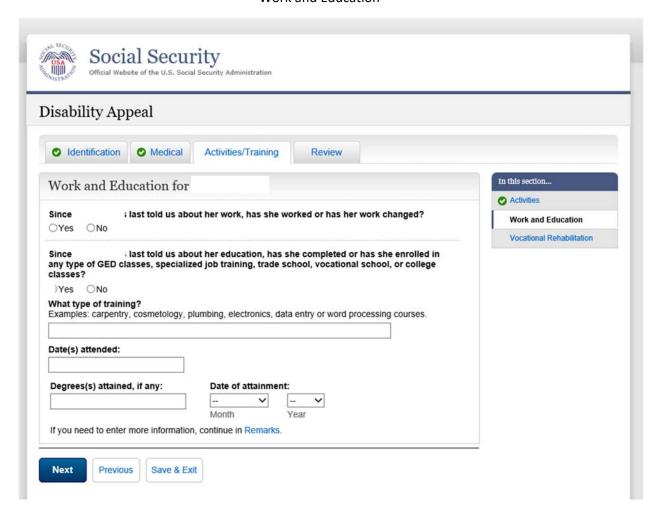
Details of Other Medical Information	
Name of Organization:	
Claim or ID Number, if any:	
Address:	
Country:	
Street Address:	
Street Line 1:	
Street Line 2:	
City/Town: State/Territory: ZIP Code:	
V	
Phone Number: U.S. O International	
10-digit Number Ext	
To digit tuttion.	
Contacts with this Organization	
Examples: visits to workers' compensation attorney, doctor/clinic in prison, or school counselor. Enter the closest date(s) oan remember. Examples: 6/2/2015; June 2015; Summer 2015.	
Date of First Contact:	
Date of Last Contact:	
Date of Next Contact, if any:	



Activities



Work and Education



Voc Rehab

In this section... Vocational Rehabilitation, Employment, or Other Support Services for Activities Work and Education participation in: We need to know about . Vocational Rehabilitation · 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 · any program providing vocational rehabilitation, employment services, or other support services to help him go to work · a Plan to Achieve Self-Support (PASS) · an individualized education program (IEP) through an educational institution (if a student age 18-21) last told us about his vocational rehabilitation, has he participated, or is he participating, in one of these programs? Yes ONo Name of Organization or School: Name of Counselor, Instructor, or Job Coach: Phone Number: ⊕ U.S. ○ International 10-digit Number Address: Country: $\overline{\mathbf{v}}$ Street Address: Street Line 1: Street Line 2: Add Line City/Town: ZIP Code: State: Date when _____ started participating in the plan or program: If you need to enter more information, continue in Remarks. Next Previous Save & Exit

Remarks

Additional Remarks for	In this section	
	Remarks	
Please provide any additional information Use this space to provide any information	Medical Release	
any additional information John Public feels we should know about. (2000 characters maximum)	Summary	
Characters remaining: 2000		
Next Previous Save & Exit		
TIEVIOUS SAVE & EXIL		

Medical Release

Disability Appeal

