

# 1<sup>st</sup> Party

## Section 1: Information about the Disabled Person

### Apply for Benefits 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 Tony Tiger

**Mailing Address:**

**Country:**

**Street Address:**  
Street Line 1:   
Street Line 2:  [+ Add Line](#)

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

**Daytime Phone Number:**  
 U.S.    International  
  
10-digit Number

**Another phone number where we may reach you:**  
 U.S.    International  
     
10-digit Number   Ext

**In this section...**

Contact Information

Re-entry Number

**Your privacy is important.**  
For details about our use of your information, we encourage you to read our [Privacy Act Statement](#).

## Ability to Communicate in English

**Can you speak and understand English?**

Yes    No

**Can you read and understand English?**

Yes    No

**Can you write more than your name in English?**

Yes    No

## Other Names

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

Examples: Maiden name, other married name, or nickname

Yes  No

Next

## Section 2-Contacts

### 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: 1324 Some Street, Baltimore, MD 21201  
 Enter a different address:

Address:

Country:

Street Address:

Street Line 1:

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

#### In this section...

[Conditions](#)

**Other Contact**

[Doctors](#)

[Hospitals](#)

[Tests](#)

[Medicines](#)

[Other Medical Records](#)

<b>City/Town:</b>	<b>State/Territory:</b>	<b>ZIP Code:</b>
<input type="text"/>	<input type="text" value="--"/>	<input type="text"/>

---

**What is the daytime phone number of this person?**

Same as my phone number: (410) 325-8132  
 Enter a different daytime phone number:

---

### Preferred Language

**Can this person speak and understand English?**

Yes    No

**What language does this person prefer?**

---

### Section 3: Medical Conditions

### Conditions for Tony Tiger

**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:**

**In this section...**

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

What is your weight without shoes?

lbs

Does your condition cause you pain or other symptoms?

Yes  No

#### Section 4: Work Activity

### Work Activity for Tony Tiger

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.

<input type="text" value="-"/> <input type="button" value="v"/>	<input type="text" value="-"/> <input type="button" value="v"/>	<input type="text"/>
Month	Day	Year

**Why did you stop working?**

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

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

Yes  No

Next

Previous

Save & Exit

If yes,

**When did you make changes?**

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

Month Day Year

[Next](#)

[Previous](#)

[Save & Exit](#)

### Job History for Tony Tiger

**Since Sep 10, 2011, have you had gross earnings greater than \$1000 in any month? Do not count sick leave, vacation, or disability pay.**

We may contact you for more information.

Yes  No

**In this section...**


[Work Status](#)

[Work Activity](#)

[Job History](#)

[Education](#)

## Section 5 : Education and Training

Text Size  | Accessibility Help








# Social Security

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

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### Apply for Benefits

1  Provide Background Information2  Provide Disability Information3  Sign Medical Release4  Confirmation

 Identification Medical Work/EducationRemarksReview

#### Education for Jane Doe

**Highest Grade Completed:**  
If you did not complete the entire school year, select the previous year that you completed. If you have education equivalent to high school from another country, select 12th Grade.

v

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

--

v

Month                      Year

**School Name:**

**Location of School:**

United States or U.S. Territory     Other

--

v

City/Town                      State/Territory

**Did you receive special education, such as through an Individualized Education Plan (IEP) or equivalent education?** [More Info](#)

Yes     No

**In this section...**

-  [Work Status](#)
-  [Education](#)

**Where did you last receive special education?**

If the same school as entered above, select the check box below. Otherwise, please provide the name and location of the school below.

Same school as above

**School Name:**

Enter the name of the school where you last received special education.

**Location of School:**

United States or U.S. Territory  Other

City/Town

Country

**Have you had special education at more than one school?**

Yes  No

**Special Education Start Date:**

Enter the approximate date you started to receive special education.

Month

Year

**Special Education End Date:**

If you are still receiving special education, select the check box below. Otherwise, please provide the approximate end date.

Month

Year

Still receiving Special Education

**Last Grade You Received Special Education:**

**Reason(s) for IEP or equivalent education:**

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

Characters remaining: 1000

## Training

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

Yes  No

### Type of Program:

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

Characters remaining: 1000

### Date Program Completed:

Enter the approximate date when you completed the program.

--    
Month Year

## Language Information

What written language do you use every day in most situations (at home, work, school, in community, etc.)?

If the language is not listed, please select 'Other' and provide the language below.

--

If 'Other' is selected, please specify language:

In the language you identified above, can you read a simple message, such as a shopping list or short and simple notes?

Yes  No

In the language you identified above, can you write a simple message, such as a shopping list or short and simple notes?

Yes  No

Next

Previous

Save & Exit



## Section 6: Work History

### 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:

Next

Previous

Save & Exit

### 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

If yes,

## Job Details

### Describe this job: What did he do all day?

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

Characters remaining: 1000

### In this job, did he use machines, tools, or equipment?

Yes  No

### In this job, did he use technical knowledge or skills?

Yes  No

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

Yes  No

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

Do not include breaks and lunch.

### Did he walk?

Yes  No

**Did you walk?**

Yes  No

---

**Did you stand?**

Yes  No

---

**Did you sit?**

Yes  No

---

**Did you climb?**

Yes  No

---

**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

**Did you write, type or handle small objects?**

Yes  No

**Did you 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

**Did you write, type or handle small objects?**

Yes  No

**Did you 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

**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

**Were you a lead worker?**

Yes  No

**Next**

Previous

Save & Exit

## Section 7: Medicines

### Medicines

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

Status	Name of Medicine	Reason	Prescribed/Recommended by	Actions
No Medicines have been added.				

In this section...

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

## Section 8: Medical Treatment

### Tests



**Social Security**

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

## 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 Doctor/Healthcare Professional" or "Other Hospital/Clinic".

This provider ordered this test more than once.

## Doctors and Other Healthcare Professionals



# Social Security

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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 Tony Tiger

If you do not have any **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.

Status	Doctor/Healthcare Professional	City	Phone	Actions
<b>No Doctors/Healthcare Professionals have been added.</b>				

#### In this section...

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

## Doctor/Healthcare Professional Details

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Title	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 Line](#)

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

## Medicines Recommended or Prescribed by this Doctor/Healthcare Professional

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

Yes  No



## 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: 1000

## 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 character maximum)

Characters remaining: 1000

Save

Cancel

## Hospitals and Clinics

### 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 Tony Tiger

If you do not have any **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.

Status	Hospital/Clinic	City	Phone	Actions
No Hospitals/Clinics have been added.				

Add

#### In this section...

Conditions

Other Contact

Doctors

**Hospitals**

Tests

Medicines

Other Medical Records

Next

Previous

Save & Exit

#### 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 Line

**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

**Did you have an inpatient stay at this hospital/clinic?**

Inpatient stay means you have stayed at least one night.

Yes  No

**Did you have an outpatient visit at this hospital/clinic, or do you have one scheduled?** [More Info](#)

Outpatient visit means you went home the same day.

Yes  No

### Tests Ordered by this Hospital/Clinic [More Info](#)

**Have any of the doctors at this hospital/clinic ordered any tests for you?**

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

Yes  No

### Medicines Recommended or Prescribed by this Hospital/Clinic

**Have any of the doctors at this hospital/clinic recommended or prescribed any medicines for you?**

Yes  No

### Medical Conditions Treated by this Hospital/Clinic

**What medical conditions were treated or evaluated by this hospital/clinic?**

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

Characters remaining: 1000

## 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: 1000

Save

Cancel

## Section 8: Other Medical Information

### Other Medical Records for Tony Tiger

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 sources of **other medical records**, please click the **Next** button.

Status	Name of Organization/Office	City	Phone	Actions
No Medical Records have been added.				

Add

#### In this section...

✓ Conditions

✓ Other Contact

✓ Doctors

✓ Hospitals

✓ Tests

✓ Medicines

**Other Medical Records**

Next

Previous

Save & Exit

## Other Medical Record 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 Line](#)

**City/Town:**

**State/Territory:**

**ZIP Code:**

**Daytime Phone Number:**

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:**

**Reason for Visits or Services:**

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

Characters remaining: 1000

# 3<sup>rd</sup> Party

## Section 1: Information about the Disabled Person

### Contact Information for Tony Tiger

**Mailing Address:**

**Country:**

**Street Address:**  
Street Line 1:   
Street Line 2:

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

**Daytime Phone Number:**  
 U.S.  International  
  
10-digit Number

**Another phone number where we may reach Tony Tiger:**  
 U.S.  International  
   
10-digit Number Ext

**In this section...**

- Preparer's Contact Information
- Contact Information**
- Re-entry Number

**Your privacy is important.**  
For details about our use of your information, we encourage you to read our [Privacy Act Statement](#).

### Ability to Communicate in English

**Can Tony Tiger speak and understand English?**  
 Yes  No

**Can Tony Tiger read and understand English?**  
 Yes  No

**Can Tony Tiger write more than his name in English?**  
 Yes  No

### Other Names

**Has Tony Tiger used any other names on medical or educational records?**  
Examples: Maiden name, other married name, or nickname  
 Yes  No

## Section 2: Contacts

### Someone Who Knows About Tony Tiger's Conditions

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

**Does Tony Tiger know someone we can contact about his condition?**

Yes  No

**Name:**

First Middle Last Suffix

**Relationship to Tony Tiger:**

**What is the address of this person?**

- Same as Tony Tiger's address: 1324 Some Street, Baltimore, MD 21208  
 Enter a different address:

**What is the daytime phone number of this person?**

- Same as Tony Tiger's phone number: (410) 325-8132  
 Enter a different daytime phone number:

### Preferred Language

**Can this person speak and understand English?**

Yes  No

**What language does this person prefer?**

In this section...

Conditions

**Other Contact**

Doctors

Hospitals

Tests

Medicines

Other Medical Records

Next

Previous

Save & Exit



### Section 3: Medical Conditions

#### Conditions for Tony Tiger

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:

#### In this section...

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

What is his weight without shoes?

lbs

Does his condition cause him pain or other symptoms?

Yes  No

### Section 4: Work Activity:

#### Work Activity for Tony Tiger

We need to know more about Tony Tiger's reasons for stopping work and whether he made any changes in his work as a result of his condition(s).

When did he stop working?

If he doesn't know the exact date, enter the closest date he can remember.

--  --   
Month Day Year

Why did he stop working?

- Because of his condition
- Because of his condition AND other reasons
- Because of other reasons

Did his condition(s) cause him to make changes in his work activity before he stopped working?

[More Info](#)

Yes  No

When did he make changes?

If he doesn't know the exact date, enter the closest date he can remember.

--  --   
Month Day Year

#### In this section...

- Work Status
- Work Activity
- Education

Next

Previous

Save & Exit

## Job History for Tony Tiger

Since Sep 10, 2011, has Tony Tiger had gross earnings greater than \$1000 in any month? Do not count sick leave, vacation, or disability pay.

We may contact him for more information.

Yes  No

### In this section...

Work Status


Work Activity

Job History

Education

## Section 5: Education and Training

Text Size Accessibility Help



# Social Security

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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

### Education for John Doe

**Highest Grade Completed:**  
If John Doe did not complete the entire school year, select the previous year that he completed. If he has education equivalent to high school from another country, select 12th Grade.

1

**Date Completed:**  
Enter the date when John Doe most recently completed a school year as close as he can remember.

--      
Month   Year

**School Name:**

**Location of School:**  
 United States or U.S. Territory    Other

  --   
City/Town   Country

**Did John Doe receive special education, such as through an Individualized Education Plan (IEP) or equivalent education?** [More Info](#)

Yes    No

### In this section...

Work Status

Education

**Where did John Doe last receive special education?**

If the same school as entered above, select the check box below. Otherwise, please provide the name and location of the school below.

Same school as above

**School Name:**

Enter the name of the school where John Doe last received special education.

**Location of School:**

United States or U.S. Territory  Other

City/Town

State/Territory

**Has he had special education at more than one school?**

Yes  No

**Special Education Start Date:**

Enter the approximate date he started to receive special education.

Month

Year

**Special Education End Date:**

If he is still receiving special education, select the check box below. Otherwise, please provide the approximate end date.

Month

Year

Still receiving Special Education

**Last Grade John Doe Received Special Education:**

**Reason(s) for IEP or equivalent education:**

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

Characters remaining: 1000

## Section 5: Education and Training

### Education and Training for Tony Tiger

**Highest Grade Completed:**

If Tony Tiger did not complete the entire school year, select the previous year that he completed.

**Has Tony Tiger completed any type of special job training, trade or vocational school?**

Yes  No

### Special Education

**Did Tony Tiger attend special education classes?** [? More Info](#)

Yes  No

**School Name:**

**Location of School:**

United States or U.S. Territory  Other

City/Town

State/Territory

#### In this section...

[Work Status](#)

[Work Activity](#)

[Job History](#)

[Education](#)

## Training

Has John Doe completed any type of specialized job training, trade, or vocational school?

Yes  No

### Type of Program:

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

Characters remaining: 1000

### Date Program Completed:

Enter the approximate date when he completed the program.

--

Month

Year

## Language Information

What written language does John Doe use every day in most situations (at home, work, school, in community, etc.)?

If the language is not listed, please select 'Other' and provide the language below.

--

If 'Other' is selected, please specify language:

In the language you identified above, can John Doe read a simple message, such as a shopping list or short and simple notes?

Yes  No

In the language you identified above, can John Doe write a simple message, such as a shopping list or short and simple notes?

Yes  No

Next

Previous

Save & Exit

## Section 6: Job History

### Job Listing

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

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

Next

Previous

Save & Exit

If yes,

### Job Details

**Describe this job: What did he do all day?**

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

Characters remaining: 1000

**In this job, did he use machines, tools, or equipment?**

Yes  No

**In this job, did he use technical knowledge or skills?**

Yes  No

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

Yes  No

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

Do not include breaks and lunch.

**Did he walk?**

Yes  No

Job Details continued

**Did he walk?**

Yes  No

---

**Did he stand?**

Yes  No

---

**Did he sit?**

Yes  No

---

**Did he climb?**

Yes  No

---

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

Yes  No

---

**Did he kneel (bending legs to rest on knees)?**

Yes  No

---

**Did he crouch (bending legs & back down & forward)?**

Yes  No

---

**Did he crawl?**

Yes  No

---

**Did he handle large objects?**

Yes  No

**Did he write, type or handle small objects?**

Yes  No

**Did he reach?**

Yes  No

**Please describe what he lifted, how far he carried things, and how often he was required to do so in his job:**

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

Characters remaining: 1000

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

-- ▼

**What was the heaviest weight he ever lifted in this job?**

-- ▼

**Did he supervise other people in this job?**

Yes  No



**Did he write, type or handle small objects?**

Yes  No

**Did he reach?**

Yes  No

**Please describe what he lifted, how far he carried things, and how often he was required to do so in his job:**


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

Characters remaining: 1000

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

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

Did he supervise other people in this job?

Yes  No

Was he a lead worker?

Yes  No

Next

Previous

Save & Exit

## Section 7: Medicines

### Medicines

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

Status	Name of Medicine	Reason	Prescribed/Recommended by	Actions
No Medicines have been added.				


Add


Next

Previous

Save & Exit

#### In this section...

 [Conditions](#)

 [Other Contact](#)

 [Doctors](#)

 [Hospitals](#)


 [Tests](#)

#### Medicines

[Other Medical Records](#)

## Section 8: Medical Treatment

### Test Details



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### Apply for Benefits

#### Test Details

**Kind of Test:**

**Date of Test:** [More Info](#)

**Who sent him or will send him for this test?**  
If the provider's name is not in the list, select "Other Doctor/Healthcare Professional" or "Other Hospital/Clinic".

This provider ordered this test more than once.

### Doctor and Other Healthcare Professionals



## 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 Tony Tiger

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

- If he was 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 him for the conditions related to his disability.
- Give each person's first and last name if possible.

Status	Doctor/Healthcare Professional	City	Phone	Actions
No Doctors/Healthcare Professionals have been added.				

Add

#### In this section...

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

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

### Doctor/Healthcare Professional Details

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Title	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 Line](#)

City/Town:

State/Territory:

ZIP Code:

Doctor/Healthcare Professional's Phone Number:

U.S.  International

10-digit Number  Ext

Patient ID Number, if known:

## Treatment Dates with this Doctor/Healthcare Professional

Please give us the closest date(s) he 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 him?**

This includes any medical tests he has had or will have.

Yes  No

## Medicines Recommended or Prescribed by this Doctor/Healthcare Professional

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

Yes  No

## 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: 1000

## Treatment from this Doctor/Healthcare Professional

### What treatment did he 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 character maximum)

Characters remaining: 1000

Save

Cancel

## Hospitals and Clinics

### 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 Tony Tiger

If he does not have any **hospitals/clinics** to enter, click the **Next** button.

Include all hospitals and clinics where he has been treated for the condition(s) related to his disability.

Status	Hospital/Clinic	City	Phone	Actions
No Hospitals/Clinics have been added.				

Add

#### In this section...

[Conditions](#)

[Other Contact](#)

[Doctors](#)

#### Hospitals

[Tests](#)

[Medicines](#)

[Other Medical Records](#)

**Next**

Previous

Save & Exit

## Hospital/Clinic Details

**Name of Hospital/Clinic:**

**Name of Healthcare Professional who treated him, 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 Line](#)

**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 he have any emergency room (ER) visits at this hospital/clinic?**

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

Yes  No

**Did he have an inpatient stay at this hospital/clinic?**

Inpatient stay means he has stayed at least one night.

Yes  No

**Did he have an outpatient visit at this hospital/clinic, or does he have one scheduled?** [? More Info](#)

Outpatient visit means he went home the same day.

Yes  No

## Tests Ordered by this Hospital/Clinic [? More Info](#)

**Have any of the doctors at this hospital/clinic ordered any tests for him?**

This includes any medical tests he has had or will have.

Yes  No

## Medicines Recommended or Prescribed by this Hospital/Clinic

**Have any of the doctors at this hospital/clinic recommended or prescribed any medicines for him?**

Yes  No

## Medical Conditions Treated by this Hospital/Clinic

**What medical conditions were treated or evaluated by this hospital/clinic?**

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

Characters remaining: 1000

## Treatment from this Hospital/Clinic

**What treatment did he 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: 1000

**Save**

Cancel

## Medical Tests for Tony Tiger

If he does not have any **medical tests** to enter, click the **Next** button.

Status	Name of the Test	Test ordered by	Actions
No Tests have been added.			

Add

### In this section...

✔ Conditions

✔ Other Contact

✔ Doctors

✔ Hospitals

#### Tests

Medicines

Other Medical Records

Next

Previous

Save & Exit

## Test Details

Kind of Test:

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

Who sent him or will send him for this test?

If the provider's name is not in the list, select "Other Doctor/Healthcare Professional" or "Other Hospital/Clinic".

This provider ordered this test more than once.

Save

Cancel

## Section 9: Other Medical Information

### Other Medical Records for Tony Tiger

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 he does not have any sources of **other medical records**, please click the **Next** button.

Status	Name of Organization/Office	City	Phone	Actions
No Medical Records have been added.				

Add

#### In this section...

- ✓ Conditions
- ✓ Other Contact
- ✓ Doctors
- ✓ Hospitals
- ✓ Tests
- ✓ Medicines

#### Other Medical Records

Next

Previous

Save & Exit

## Other Medical Record 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 Line](#)

**City/Town:**

**State/Territory:**

**ZIP Code:**

**Daytime Phone Number:**

U.S.  International

10-digit Number

Ext

**First visit:**

Please give us the closest date he can remember.

**Last visit:**

Please give us the closest date he can remember.

**Next visit:**

Leave blank if no appointment scheduled.

**Case Number, if any:**

**Reason for Visits or Services:**

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

Characters remaining: 1000

Save

Cancel