



# DESIGN SPECIFICATIONS DOCUMENT

## PRW SYSTEMS UPDATE

### V1.3



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## 1. Design Specification Document Version Information

The first release of this design specifications document as a project deliverable is numbered 1.0.

Subsequent revisions are numbered 1.1, 1.2, 1.3, etc. Content revisions are listed below with corresponding page numbers.

[Any circulating drafts should be noted with a DRAFT watermark and numbered 0.1, 0.2, 0.3, etc.]

<b>Version Number</b>	<b>Date</b>	<b>Content Revisions</b>	<b>Page #</b>	<b>Revised by</b>
1.0 (First Release)	1/12/2024	First version (baseline). First party only.		
1.1 (First Revision)	2/5/2024	Response to edits made by Policy on 1/22/2024 First party only.		
1.2	2/5/2024	Updated language on job001 sw&cw. First party only		
1.3	3/29/2024	Added 3 <sup>rd</sup> party screens. Updated 1 <sup>st</sup> party screens.		

## 2. About this Document


**Intended Audience:** This design specifications document is intended to serve the needs of SSA developers building user interfaces, especially those working with the User Experience Framework (UEF). It contains information that can also be useful to analysts, validation staff, and other project team members.

**Intended Use:** Use this document in conjunction with the other UXG-related project resources (most notably the online interactive prototype) to guide development of the user interfaces designed by the UXG. See the next section of this document for a link to the prototype.

**What's Included/What's Not:** The screen captures and accompanying information included in this design specifications document relate only to the user interface portion(s) of the project that the UXG has been tasked to research, design, prototype and/or evaluate. Therefore, not all project-related web pages, application screens, menus, interactions, conditions and/or variances may be illustrated and explained in this document. In addition, user entries and data displays are simulated. Refer to the related business process documentation and functional requirements for supplemental information. Please contact the UXG Team Lead and your Project Manager regarding design-related issues that are not addressed in this document.

### 3. Pages

### 3.1. pin001 - 1 - Personal Information



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

OMB No. 0960-0579  
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 Cameron Ford

**Mailing Address:**

**Country:**  
United States or U.S. Territory

**Street Address:**

Street Line 1:

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

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

**Daytime Phone Number:**  
Daytime phone number(s) where we can call to speak with you or leave a message, if needed.

**Primary**  
 U.S.    International

    
10-digit Number   Ext

**Secondary (if available)**  
 U.S.    International

    
10-digit Number   Ext

**Email Address:**  
We will send an acknowledgment to this address

**Confirm Email Address:**  
Please retype to confirm your email address

**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, other names, or nickname

Yes  No


**Next**

Previous

Save & Exit



### 3.2. pin001 - 3 - Personal Information



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

OMB No. 0960-0579  
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 Cameron Ford

**Mailing Address:**

**Country:**

**Street Address:**

Street Line 1:

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

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

**Daytime Phone Number:**  
Daytime phone number(s) where we can call to speak with them or leave a message, if needed.

**Primary**  
 U.S.    International

    
10-digit Number   Ext

**Secondary (if available)**  
 U.S.    International

    
10-digit Number   Ext

**Email Address:**  
We will send an acknowledgment to this address

**Confirm Email Address:**  
Please retype to confirm your email address

**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, other names, or nickname


Yes  No

**Next**

Previous

Save & Exit

### 3.3. alg001 - 1 - Conditions



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

OMB No. 0960-0579  
Paperwork Reduction Act

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

Identification    Medical    **Work/Education**    Remarks    Review

### Conditions for Cameron Ford

**Separately** list each physical and/or mental condition that limits your ability to work. (Example: Back Injury, Arthritis, Diabetes, Glaucoma, Depression, Blind). If you have cancer, please include the type and stage. We will consider these conditions whether or not you have been receiving treatment. Use your own words if you do not know the medical names. **Please enter only one condition per box.**

**1st Condition:**

**2nd Condition:**

**3rd Condition:**

**4th Condition:**

**5th Condition:**

**6th Condition:**

**7th Condition:**

**8th Condition:**

**9th Condition:**

**10th Condition:**

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

#### In this section...

- [Condition](#)
- [Other Contact](#)
- [Doctors](#)
- [Hospitals](#)
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

**Your privacy is important.**

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

**What are your preferred measurement units?**  
 Feet, Inches, and Pounds     Centimeters and Kilograms


**What is your height?**  
--    --  
Feet    Inches

**What is your weight?**  
  
Pounds

---

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

### 3.4. alg001 - 3 - Conditions



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

OMB No. 0960-0579  
Paperwork Reduction Act

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

Identification    Medical    **Work/Education**    Remarks    Review

### Conditions for Cameron Ford

**Separately** list each physical and/or mental condition that limits Cameron Ford's ability to work. (Example: Back Injury, Arthritis, Diabetes, Glaucoma, Depression, Blind). If Cameron Ford has cancer, please include the type and stage. We will consider these conditions whether or not they have been receiving treatment. Use Cameron Ford's own words if they do not know the medical names. **Please enter only one condition per box.**

**1st Condition:**

**2nd Condition:**

**3rd Condition:**

**4th Condition:**

**5th Condition:**

**6th Condition:**

**7th Condition:**

**8th Condition:**

**9th Condition:**

**10th Condition:**

Cameron Ford have more than 10 conditions that limit their ability to work.

#### In this section...

- [Condition](#)
- [Other Contact](#)
- [Doctors](#)
- [Hospitals](#)
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

**Your privacy is important.**

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

**What are their preferred measurement units?**

Feet, Inches, and Pounds     Centimeters and Kilograms

**What is their height?**

-- ▾    -- ▾

Feet    Inches

**What is their weight?**


Pounds

**Next**

Previous

Save & Exit

### 3.5. alg001 - 1 - Conditions (show metric)



# Social Security

Official Website of the U.S. Social Security Administration

OMB No. 0960-0579  
Paperwork Reduction Act

## Apply for Benefits

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

Identification   Medical   **Work/Education**   Remarks   Review

### Conditions for Cameron Ford

**Separately** list each physical and/or mental condition that limits your ability to work. (Example: Back Injury, Arthritis, Diabetes, Glaucoma, Depression, Blind). If you have cancer, please include the type and stage. We will consider these conditions whether or not you have been receiving treatment. Use your own words if you do not know the medical names. **Please enter only one condition per box.**

**1st Condition:**

**2nd Condition:**

**3rd Condition:**

**4th Condition:**

**5th Condition:**

**6th Condition:**

**7th Condition:**

**8th Condition:**

**9th Condition:**

**10th Condition:**

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

**In this section...**

- [Condition](#)
- [Other Contact](#)
- [Doctors](#)
- [Hospitals](#)
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

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

**What are your preferred measurement units?**

Feet, Inches, and Pounds     Centimeters and Kilograms

**What is your height?**

Centimeters

**What is your weight?**

Kilograms


**Next**

Previous

Save & Exit



### 3.6. alg001 - 3 - Conditions (show metric)



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

OMB No. 0960-0579  
Paperwork Reduction Act

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

Identification    Medical    **Work/Education**    Remarks    Review

### Conditions for Cameron Ford

**Separately** list each physical and/or mental condition that limits Cameron Ford's ability to work. (Example: Back Injury, Arthritis, Diabetes, Glaucoma, Depression, Blind). If Cameron Ford has cancer, please include the type and stage. We will consider these conditions whether or not they have been receiving treatment. Use Cameron Ford's own words if they do not know the medical names. **Please enter only one condition per box.**

**1st Condition:**

**2nd Condition:**

**3rd Condition:**

**4th Condition:**

**5th Condition:**

**6th Condition:**

**7th Condition:**

**8th Condition:**

**9th Condition:**

**10th Condition:**

Cameron Ford have more than 10 conditions that limit their ability to work.

#### In this section...

- [Condition](#)
- [Other Contact](#)
- [Doctors](#)
- [Hospitals](#)
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

**Your privacy is important.**

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

**What are their preferred measurement units?**

- Feet, Inches, and Pounds     Centimeters and Kilograms

**What is their height?**

Centimeters

**What is their weight?**


Kilograms

**Next**

Previous

Save & Exit

### 3.7. con001 - 1 - Other Contact



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification    Medical    Work/Education    Remarks    Review

### Someone Who Can Help With <Claimant's Name>'s Claim

Give the names of up two people (other than your doctor) we can contact who knows about your medical condition(s) and can help you with your claim and help us reach you if you become unavailable.

**Is there someone we can contact who can help with your claim, if needed?**  
Examples include a family member, friend, or neighbor

Yes     No

Please provide the names of up to two people (other than your doctors) we can contact who know about your medical condition(s) and can help with your claim and help us reach you if you become unavailable.

**In this section...**

- Condition
- Other Contact**
- Doctors
- Hospitals
- Tests
- Medicines
- Other Medical Information

#### Contact 1

**Name:**

\*First    Middle    \*Last    Suffix

**Relationship to you:**

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

Same as my address: XXX ST, CITY, STATE, ZIP

Enter a different address:

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

Same as my phone number: (XXX) XXX-XXXX

Enter a different phone number:

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

Yes     No

**Do you have a second contact you can add?**

Yes     No

### Contact 2

**Name:**

\*First Middle \*Last Suffix

**Relationship to you:**

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

Same as my address: XXX ST, CITY, STATE, ZIP

Enter a different address:

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


Same as my phone number: (XXX) XXX-XXXX

Enter a different phone number:

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

Yes  No

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



## Social Security

Official Website of the U.S. Social Security Administration

### Apply for Benefits

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

Identification   Medical   Work/Education   Remarks   Review

#### Someone Who Can Help With <Claimant's Name>'s Claim

Give the names of up to two people (other than your doctor) we can contact who knows about your medical condition(s) and can help you with your claim and help us reach you if you become unavailable.

**Is there someone we can contact who can help with your claim, if needed?**  
Examples include a family member, friend, or neighbor

Yes    No


**⚠ We recommend that you provide at least one contact, if available. Providing the name of someone who knows you may help us make a decision on your claim**

**In this section...**

- Condition
- Other Contact**
- Doctors
- Hospitals
- Tests
- Medicines
- Other Medical Information

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

### 3.8. con001 - 3 - Other contact



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification   Medical   Work/Education   Remarks   Review

### Someone Who Can Help With <Claimant's Name>'s Claim

Give the names of up two people (other than their doctor) we can contact who knows about teir medical condition(s) and can help <Claimant Name> with their claim and help us reach them if they become unavailable.

**Is there someone we can contact who can help with their claim, if needed?**  
Examples include a family member, friend, or neighbor


Yes    No

**⚠ We recommend that they provide at least one contact, if available. Providing the name of someone who knows them may help us make a decision on their claim**

In this section...

- Condition
- Other Contact**
- Doctors
- Hospitals
- Tests
- Medicines
- Other Medical Information

### 3.9. doc001 - 1 - Doctors Start



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification   Medical   **Work/Education**   Remarks   Review

### Doctors and Other Healthcare Providers for Cameron Ford

If you do not have any **doctors or healthcare providers** to enter, click the **Next** button.

Add doctors and other healthcare providers that:

- You have seen in the past
- You are seeing now
- You have a future appointment scheduled

Healthcare providers include:

- Doctors
- Psychiatrist
- Therapist
- Physical therapist
- Other medical professionals


Status	Doctor/Healthcare provider	City	Phone	Actions
No Doctors/Healthcare providers have been added.				

In this section...

- [Condition](#)
- [Other Contact](#)
- [Doctors](#)
- [Hospitals](#)
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

### 3.10. doc001 - 3 - Doctors Start



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification   Medical   **Work/Education**   Remarks   Review

### Doctors and Other Healthcare Providers for Cameron Ford

If they do not have any **doctors or healthcare providers** to enter, click the **Next** button.

Add doctors and other healthcare providers that:

- They have seen in the past
- They are seeing now
- They have a future appointment scheduled

Healthcare providers include:

- Doctors
- Psychiatrist
- Therapist
- Physical therapist
- Other medical professionals


Status	Doctor/Healthcare provider	City	Phone	Actions
No Doctors/Healthcare providers have been added.				

In this section...

- [Condition](#)
- [Other Contact](#)
- [Doctors](#)
- [Hospitals](#)
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

### 3.11. doc002 - 1 - Doctor Information



## Social Security

Official Website of the U.S. Social Security Administration

---

### Apply for Benefits

---

#### Doctor/Healthcare Provider Details

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

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

**Name of Facility or Office, if Applicable:**

**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 Provider's Phone Number:**

U.S.     International

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

---

#### Treatment Dates with this Doctor/Healthcare Provider

Enter at least one date that is applicable to you. Provide all treatment dates (past or future) that you can remember.

**Date First Seen:**

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

**Date Last Seen:**

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



**Date of Next Appointment:**

--

Month Year

**Medical Conditions Treated by this Doctor/Healthcare Provider**

**What medical conditions were treated or evaluated by this doctor/healthcare provider?** [More Info](#)

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


Characters remaining: XXXX

**Save**

### 3.12. More Info - Name of Health Care Provider

## Name of Healthcare Provider

Last reviewed or modified 01/02/2024



We need the names of physicians, psychiatrists, nurse practitioners, therapists, physical therapists, or other medical professionals who treated you. You can check your medical bills, online medical chart, the internet, or on your current medicine containers for doctors' names.

If you do not know your doctor's or healthcare provider's first name, you may give us only the last name.

Examples:

- Dr. Page
- Ms. Butler
- Dr. Joe Camp Jr.

If you go to a clinic and do not see the same doctor everytime, you may give us only the names of the clinic.

Examples:

- Sherwood Mental Health Clinic
- Lovett Center for the Blind

[Close](#)

### 3.13. More Info - conditions

## Medical Conditions

Last reviewed or modified 03/19/2019




The following list includes examples of some common medical conditions:

- Back Injury
- Arthritis
- Diabetes
- Glaucoma
- Depression
- Blind

[Close](#)

### 3.14. doc002 - 3 - Doctor Information



# Social Security

Official Website of the U.S. Social Security Administration

---

## Apply for Benefits

### Doctor/Healthcare Provider Details

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

--				
Title	First	Middle	Last	Suffix

**Name of Facility or Office, if Applicable:**

**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:**  
United States or U.S. Territory

**Street Address:**

Street Line 1:

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

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

**Doctor/Healthcare Provider's Phone Number:**

U.S.     International

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

### Treatment Dates with this Doctor/Healthcare Provider

Enter at least one date that is applicable to them. Provide all treatment dates (past or future) that they can remember.

**Date First Seen:**

--	<input type="text"/>
Month	Year

**Date Last Seen:**

--	<input type="text"/>
Month	Year

**Date of Next Appointment:**

--    
Month Year

**Medical Conditions Treated by this Doctor/Healthcare Provider**


**What medical conditions were treated or evaluated by this doctor/healthcare provider?** [More Info](#)

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

Characters remaining: XXXX

**Save**

### 3.15. hos001 - 1 - Hospitals



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification   Medical   **Work/Education**   Remarks   Review

### Hospitals and Clinics for Cameron Ford

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

Add all hospitals and clinics where you have been treated for your medical condition(s) including :

- Outpatient facilities
- Psychiatric facilities
- Emergency rooms
- Urgent care facilities


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

In this section...

- [Condition](#)
- [Other Contact](#)
- [Doctors](#)
- [Hospitals](#)
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

### 3.16. hos001 - 3 - Hospitals



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification   Medical   **Work/Education**   Remarks   Review

### Hospitals and Clinics for Cameron Ford

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

Add all hospitals and clinics where they were treated for your medical condition(s) including :

- Outpatient facilities
- Psychiatric facilities
- Emergency rooms
- Urgent care facilities


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

In this section...

- [Condition](#)
- [Other Contact](#)
- [Doctors](#)
- [Hospitals](#)
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

### 3.17. hos002 - 1 - Hospital Information



## Social Security

Official Website of the U.S. Social Security Administration

---

### Apply for Benefits

---

#### Hospital/Clinic Details

**Name of Facility or Office:**

**Name of Doctor/Healthcare Provider (if known):** [? More Info](#)

Title First Middle Last Suffix

**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

---

#### Treatment Dates at this Hospital/Clinic

Enter at least 1 date that is applicable to you. Provide all treatment dates (past or future) that you can remember.

**Date First Seen:**  
   
Month Year

**Date Last Seen:**  
   
Month Year

**Date of Next Appointment:**



--      
Month      Year

### Medical Conditions Treated by this Hospital/Clinic


**What medical conditions were treated or evaluated by this hospital/clinic?** [? More Info](#)  
If you need more space, use the Remarks tab. (1000 characters maximum)

Characters remaining: XXXX

### 3.18. More Info - Name of Health Care Provider-facility

## Name of Healthcare Provider

Last reviewed or modified 01/02/2024



We need the names of physicians, psychiatrists, nurse practitioners, therapists, physical therapists, or other medical professionals who treated you. You can check your medical bills, online medical chart, the internet, or on your current medicine containers for doctors' names.

If you do not know your doctor's or healthcare provider's first name, you may give us only the last name.

Examples:


- Dr. Page
- Ms. Butler
- Dr. Joe Camp Jr.

[Close](#)

### 3.19. More Info - treatments

## Medical Conditions

Last reviewed or modified 03/19/2019




Examples of treatment include:

- Examinations
- Regular evaluations
- Check-ups
- Physical therapy
- Chemotherapy
- Counseling

**Close**

### 3.20. hos002 - 3 - hospital information



## Social Security

Official Website of the U.S. Social Security Administration

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### Apply for Benefits

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#### Hospital/Clinic Details

**Name of Facility or Office:**

**Name of Doctor/Healthcare Provider (if known):** [? More Info](#)

Title First Middle Last Suffix

**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

---

#### Treatment Dates at this Hospital/Clinic

Enter at least 1 date that is applicable to them. Provide all treatment dates (past or future) that they can remember.

**Date First Seen:**  
   
Month Year

**Date Last Seen:**  
   
Month Year

**Date of Next Appointment:**

-- Month	<input type="text"/> Year
-------------	------------------------------


  

### Medical Conditions Treated by this Hospital/Clinic

**What medical conditions were treated or evaluated by this hospital/clinic?** [More Info](#)  
If you need more space, use the Remarks tab. (1000 characters maximum)

Characters remaining: XXXX

### 3.21. tst001 - 1 - Tests



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification   Medical    Work/Education    Remarks    Review

### Medical Tests for Cameron Ford

If you do not have any **medical tests** to enter, click the **Next** button. [More Info](#)

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

In this section...

- [Condition](#)
- [Other Contact](#)
- [Doctors](#)
- [Hospitals](#)
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

## 3.22. More Info - Tests

### Medical Tests

Last reviewed or modified 03/19/2019



The following list includes descriptions of some standard medical tests you have had or will have.

**Note:** You also need to tell us about any medical tests you have had, or will have, that are not on the list.

#### **Biopsy**

A biopsy is the removal of a small piece of tissue for laboratory examination. This test is usually done to see if disease is present.

#### **Blood Test (Not HIV)**

A technician draws a blood sample to test for abnormalities.

#### **Blood Test - HIV or AIDS test**

A technician draws a blood sample to test for the presence of the Human Immunodeficiency Virus (HIV) or the Acquired Immune Deficiency Syndrome (AIDS).

#### **Breathing Test, also known as a Lung or Pulmonary Function Test**

The patient breathes into a mouthpiece to measure the amount and speed of breathing over a period of time. The patient may also be asked to exhale as long and as hard as possible.

#### **Cardiac Catheterization**

A doctor passes a thin flexible tube (catheter) into the heart, usually from the groin or arm. This test is done to get information about the heart or its blood vessels. It may also be used to determine the need for heart surgery.

#### **EEG (Electroencephalography), also known as a Brain Wave Test**

The patient sits or lies down with flat metal disks attached to the scalp. The disks are attached by wires to a machine that shows wavy lines on a chart. This test detects problems in the electrical activity of the brain.

**EKG (Electrocardiogram) Heart Test, also known as an ECG**

The patient sits, stands or lies down with small wire patches attached to the skin. The wires are attached to a machine that shows wavy lines on a chart. This test detects some heart problems.

**Hearing Test, also known as an Audiogram**

The patient wears earphones while a specialist plays different tones that are delivered to one ear at a time.

**Psychological/IQ Tests (Intelligence Quotient)**

The individual performs a series of short tasks that require either a written or a spoken response. The tasks measure a person's ability to remember, understand information, and solve problems.

**MRI/ CT (CAT) Scan**

The patient lies still on a table while it slowly passes through the center of a large machine. Some of the machines make a lot of noise. The machine makes images parts inside the body. These images show soft tissue, internal organs, and blood vessels far better than an X-ray.

**Speech / Language Test**

The patient is evaluated for a communication disorder. This may include listening, talking, reading, and writing, as well as an evaluation of the face, mouth, and tongue movements.

**Treadmill (Exercise Test), also known as a Stress Test**

The patient walks or pedals on an exercise machine while the electrical activity of the heart is measured with an electrocardiogram (ECG), and blood pressure readings are taken. This test measures the heart's reaction to the body's increased need for oxygen.

**Vision Test, also known as an Eye Examination**

The patient reads letters or looks at symbols of different sizes on an eye chart or handheld card. Other devices test the eye's reaction to light, eye movement, and side (peripheral) vision. This test measures the eye's ability to see details.




### **X-Ray**

The patient stands on the floor, or lies or sits on a table in an X-ray room. A technician positions the body to give the best X-ray view, and points the machine's tube at the correct body area. The X-ray machine makes images of bones and organs inside the body. X-rays are used for many purposes, including determining if a bone is broken, seeing whether an internal organ is infected, and looking for cancer.

**Close**

### 3.23. tst001 - 3 -Tests



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification   Medical    Work/Education    Remarks    Review

### Medical Tests for Cameron Ford

If they do not have any **medical tests** to enter, click the **Next** button. [More Info](#)

Status	Name of Test	Test ordered by	Actions
<b>No Tests have been added.</b>			

In this section...

- [Condition](#)
- [Other Contact](#)
- [Doctors](#)
- [Hospitals](#)
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

### 3.24. tst002 - 1 - Test Details

# Social Security

Official Website of the U.S. Social Security Administration

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## Apply for Benefits

---

### Test Details

---

**Kind of Test:**

**Date of Test:**

Month

Year

**Who sent you or will send you for this test?**

If the provider's name is not in the list, select "Other Doctor/Healthcare Provider."

This provider ordered this test more than once.

---

**Save**

Cancel

### 3.25. tst002 - 3 - Test Details

# Social Security

Official Website of the U.S. Social Security Administration

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## Apply for Benefits

---

### Test Details

---

**Kind of Test:**

**Date of Test:**

Month

Year

**Who sent them or will send you for this test?**

If the provider's name is not in the list, select "Other Doctor/Healthcare Provider."


This provider ordered this test more than once.

---

**Save**

Cancel

### 3.26. med001 - 1 - Medicines



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification   Medical    Work/Education    Remarks    Review

### Medicines

Are you currently taking any prescription or non-prescription medicine(s)? 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
<b>No Medicines have been added.</b>				

In this section...

- [Condition](#)
- [Other Contact](#)
- [Doctors](#)
- [Hospitals](#)
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

### 3.27. med001 - 3 -Medicines



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification   Medical    Work/Education    Remarks    Review

### Medicines

Is <Claimant Name> currently taking any prescription or non-prescription medicine(s)? If they 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 they are taking.

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

In this section...

- [Condition](#)
- [Other Contact](#)
- [Doctors](#)
- [Hospitals](#)
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)

### 3.28. med002 - 1 - Medicine Details

# Social Security

Official Website of the U.S. Social Security Administration

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## Apply for Benefits

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### Medicine Details

---

**Enter Name of Medicine:**

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


**Reason for Medicine (if known):**

**If Prescribed, Give Doctor's Name (if known):**

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

---

### 3.29. msc001 - 1 - Other Medical Records



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification    Medical     Work/Education     Remarks     Review

### Other Medical Information for Cameron Ford

Does anyone else (other than your healthcare providers) have your medical information? Examples include:

- Department of Veterans Affairs
- Social service agencies
- Welfare agencies
- Attorneys
- Prisons
- Workers compensation
- Insurance companies who have paid you disability benefits
- Vocational rehabilitation services

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 information**, please click the **Next** button.

Status	Name of Organization/Office	City	Phone	Actions
<b>No Other Medical Information has been added.</b>				


      

In this section...

- [Condition](#)
- [Other Contact](#)
- [Doctors](#)
- [Hospitals](#)
- [Tests](#)
- [Medicines](#)
- [Other Medical Information](#)



### 3.30. msc001 - 3 - Other Medical Records



## Social Security

Official Website of the U.S. Social Security Administration

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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

#### Other Medical Information for Cameron Ford

Does anyone else (other than <Claimen Name>'s healthcare providers) have their medical information?  
Examples include:

- Department of Veterans Affairs
- Social service agencies
- Welfare agencies
- Attorneys
- Prisons
- Workers compensation
- Insurance companies who have paid them disability benefits
- Vocational rehabilitation services

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 they do not have any sources of **other medical information**, please click the **Next** button.

Status	Name of Organization/Office	City	Phone	Actions
<b>No Other Medical Information has been added.</b>				

Next


Previous

Save & Exit

In this section...

- Condition
- Other Contact
- Doctors
- Hospitals
- Tests
- Medicines
- Other Medical Information

### 3.31. msc002 - 1 - Other Med Recs Details



## Social Security

Official Website of the U.S. Social Security Administration

### Apply for Benefits

#### Other Medical Information Details

**Name of Organization:**

**Phone Number:**  
 U.S.     International

     
10-digit Number    Ext

**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:**

**Name of Contact Person:**

     
First    Last

**Date of First Contact:**  
Please give us the closest date you can remember.

     
Month    Year

**Date of Last Contact:**  
Please give us the closest date you can remember.

     
Month    Year


**Date of Next Contact (if any):**  
Leave blank if no appointment scheduled.

     
Month    Year

<p><b>Claim Number (if any):</b> <input type="text"/></p> <p><b>Reason(s) for Contacts:</b> If you need more space, continue in the Remarks tab. (1000 characters maximum)</p> <div style="border: 1px solid #ccc; height: 40px; width: 100%;"></div> <p>Characters remaining: XXXX</p>	
---	--

---

### 3.32. msc002 - 3 - Other Med Recs Details



## Social Security

Official Website of the U.S. Social Security Administration

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### Apply for Benefits

---

#### Other Medical Information Details

**Name of Organization:**

**Phone Number:**  
 U.S.     International

     
10-digit Number    Ext

**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:**

**Name of Contact Person:**

     
First    Last

**Date of First Contact:**  
Please give us the closest date they can remember.

     
Month    Year

**Date of Last Contact:**  
Please give us the closest date they can remember.


     
Month    Year

**Date of Next Contact (if any):**  
Leave blank if no appointment scheduled.

     
Month    Year

<p><b>Claim Number (if any):</b> <input type="text"/></p> <p><b>Reason(s) for Contacts:</b> If you need more space, continue in the Remarks tab. (1000 characters maximum)</p> <div style="border: 1px solid #ccc; height: 40px; width: 100%;"></div> <p>Characters remaining: XXXX</p>	
<hr/>	
<p><input type="button" value="Save"/> <input type="button" value="Cancel"/></p>	

### 3.33. win001 - 1 - Work/Education Intro



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification    Medical   **Work/Education**    Remarks    Review

### Work Status for Cameron Ford

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

This section of the report asks for information about:

- when your condition(s) began to affect your ability to work;
- your work history; and
- your education and training.

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

**Are you currently working?**

No, I have never worked

No, I have stopped working


Yes, I am currently working

**Next**   Previous   Save & Exit

In this section...

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

### 3.34. win001 - 3 - Work/Education Intro



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification    Medical   **Work/Education**    Remarks    Review

### Work Status for Cameron Ford

In determining whether <Claimant Name> meets the requirements for receiving disability benefits, we must consider their work experience and job skills. [More Info](#)

This section of the report asks for information about:

- when <Claimant's Name>'s condition(s) began to affect their ability to work;
- their work history; and
- their education and training.

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

**Is <Claimant Name> currently working?**

No, they have never worked

No, they have stopped working


Yes, they are currently working

**Next**   Previous   Save & Exit

In this section...

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

### 3.35. wac001 - 1 - cw - Work Activity



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification    Medical    Work/Education    Remarks    Review

### Work Activity for Cameron Ford

We need to know whether you or your employer made any changes in your work as a result of your condition(s). [More Info](#)

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

Yes    No

**When did the changes start?**

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

--   --   --  
Month   Day   Year

In this section...


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



### 3.36. More Info - work changes

## Changes in Work Activity

Last reviewed or modified 03/19/2019



Sometimes mental and physical conditions cause people to make changes in their work activity before they stop working. Examples changes include:


- Job duties
- Hours
- Rate of pay

[Close](#)

### 3.37. More Info - work stop reasons

## Reasons for Stopping Work

Last reviewed or modified 03/19/2019




Examples include:

- Laid off
- Early retirement
- Seasonal work ended
- Business closed

[Close](#)

### 3.38. wac001 - 3 - cw - Work Activity



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification    Medical    Work/Education    Remarks    Review

### Work Activity for Cameron Ford

We need to know whether <Claimant Name> or their employer made any changes in their work as a result of their condition(s). [More Info](#)

**Has <Claimant Name>'s condition(s) caused them or <Claimant's Name>'s employer to make changes to <Claimant Name>'s work activity?**

Yes    No

**When did the changes start?**  
If they don't remember the exact date, enter the closest they can remember.


--   --   --  
Month   Day   Year

In this section...

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

### 3.39. wac001 - 1 - sw - Work Activity



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification   Medical   Work/Education   Remarks   Review

### Work Activity for Cameron Ford

We need to know more about your reasons for stopping work and whether you or your employer made any changes in your work as a result of your condition(s). [More Info](#)

**When did you stop working?**  
If you don't know the exact date, enter the closest date you can remember.

-- --   --   --  
Month   Day   Year

**Why did you stop working?**

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

**Please explain the other reasons why you stopped working.** [More Info](#)

Characters remaining: 1000

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

-- --   --   --  
Month   Day   Year

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

Yes    No

**When did the changes start?**  
If you don't know the exact date, enter the closest date you can remember.

-- --   --   --  
Month   Day   Year

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

In this section...

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

### 3.40. wac001 - 3 - sw - Work Activity



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification   Medical   Work/Education   Remarks   Review

### Work Activity for Cameron Ford

We need to know more about <Claimant's Name> reasons for stopping work and whether <Claimant Name> or their employer made any changes in your work as a result of their condition(s). [More Info](#)

**When did they stop working?**  
If you don't know the exact date, enter the closest date you can remember.

-- --   --   --  
Month   Day   Year

**Why did they stop working?**

Because of their condition  
 Because of their condition AND other reasons  
 Because of other reasons

**Please explain the other reasons why they stopped working.** [More Info](#)

Characters remaining: 1000

**Even though they stopped for other reasons, when do they believe that their condition(s) became severe enough to keep them from working?**

-- --   --   --  
Month   Day   Year

**Did <Claimant Name>'s condition(s) cause them or <Claimant's Name>'s employer to make changes in <Claimant Name>'s work activity before they stopped working?** [More Info](#)

Yes    No

**When did the changes start?**  
If they don't know the exact date, enter the closest date they can remember.


-- --   --   --  
Month   Day   Year

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

**In this section...**

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

### 3.41. job001 - 1 - cw&sw - Job History



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification    Medical   Work/Education   Remarks   Review

### Work History for Cameron Ford

**Since Sep 10, 2011, have you had any earnings greater than \$1000 before tax in any month? Do not count sick leave, vacation, or disability pay.**  
We may contact you for more information.

Yes    No

### Job Listing

List all the jobs that you had in the **five years** before you became unable to work. Start with your most recent job.

When selecting the number of jobs include:

- All job titles even if they were for the same employer
- Do not include jobs you held for less than 30 calendar days
- Self-employment (e.g. ride-share driving, hair stylist)
- Work in a foreign country

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

--

### Most Recent Job

**Job Title:**  
Example: Cashier

**Type of Business:**  
Example: Grocery store

**Start Date:**  
--     
Month   Year

**End Date:**

In this section...

- Work Status
- Work Activity
- Work History
- Education

--    
 Month Year

**Hours per Day:**

Hours Minutes

**Days per Week:**

**Rate of Pay:**

\$  --   
 Amount Frequency

## Job Details

**In a typical workday, about how many hours were you on your feet or seated?**

The hours/minutes for standing, walking, and sitting should equal the hours per day reported for this job. Do not include breaks and lunch.

**Did you stand and walk (combined)?**

Yes  No

**How long did you stand and walk (combined)?**

Hours Minutes

**Did you sit?**

Yes  No

**How long did you sit?**

Hours Minutes

**In a typical workday, did you do any of these tasks at your most recent job? If so, how long did you do it?**

The hours/minutes for these tasks should not exceed the hours per day reported for this job. This information tells us about the physical and mental requirements of your job.

**Did you stoop (i.e., bending down & forward at the waist)?**

Yes  No

**How long did you stoop?**

Hours Minutes

**Did you kneel (i.e., bending legs to rest on knees)?**

Yes  No

**How long did you kneel?**

Hours Minutes

**Did you crouch (i.e., bending legs & back down & forward)?**

Yes  No

**How long did you crouch?**

Hours Minutes

**Did you crawl (i.e., moving on hands & knees)?**

Yes  No

**How long did you crawl?**

Hours Minutes

**Did you use fingers to touch, pick, or pinch (e.g., using a mouse, keyboard, turning pages, or buttoning a shirt)?**

One Hand  Both Hands  No

**How long did you use fingers to touch, pick or pinch?**

Hours Minutes

**Did you use hands to seize, hold, grasp, or turn (e.g., holding a large envelope, a small box, a**

**How long did you use hands to hold, grasp, or turn?**

<b>hammer, or water bottle)?</b> <input type="radio"/> One Hand <input type="radio"/> Both Hands <input type="radio"/> No	<input type="text" value="0"/> <input type="text" value="0"/> Hours   Minutes
<b>Did you reach at or below the shoulder?</b> <input type="radio"/> One Arm <input type="radio"/> Both Arms <input type="radio"/> No	<b>How many hours did you reach at or below the shoulder?</b> <input type="text" value="0"/> <input type="text" value="0"/> Hours   Minutes
<b>Did you reach overhead (above the shoulder)?</b> <input type="radio"/> One Arm <input type="radio"/> Both Arms <input type="radio"/> No	<b>How long did you reach overhead?</b> <input type="text" value="0"/> <input type="text" value="0"/> Hours   Minutes
<b>Did you climb stairs or ramps?</b> <input type="radio"/> Yes <input type="radio"/> No	<b>How long did you climb stairs or ramps?</b> <input type="text" value="0"/> <input type="text" value="0"/> Hours   Minutes
<b>Did you climb ladders, ropes, or scaffolds?</b> <input type="radio"/> Yes <input type="radio"/> No	<b>How long did you climb ladders, ropes, or scaffolds?</b> <input type="text" value="0"/> <input type="text" value="0"/> Hours   Minutes
<b>For this job, describe in detail the tasks that you did in a typical workday.</b> <a href="#">More Info</a> If you need more space, use the Remarks tab. (1000 characters maximum)	
<div style="border: 1px solid #ccc; height: 40px; width: 100%;"></div> <div style="border: 1px solid #ccc; width: 100%; margin-top: 2px;"><div style="background-color: #ccc; width: 20%;"></div></div> <p>Characters remaining: 1000</p>	
<b>In this job, did you do any writing, complete reports, or perform any duties like this?</b> <input checked="" type="radio"/> Yes <input type="radio"/> No	
<b>Describe the type of report you wrote and how much time you spent on it per workday or workweek.</b> If you need more space, use the Remarks tab. (1000 characters maximum)	
<div style="border: 1px solid #ccc; height: 40px; width: 100%;"></div> <div style="border: 1px solid #ccc; width: 100%; margin-top: 2px;"><div style="background-color: #ccc; width: 20%;"></div></div> <p>Characters remaining: 1000</p>	
<b>In this job, did you supervise other people in this job?</b> <input type="radio"/> Yes <input type="radio"/> No	
<b>Describe who and what you supervised and what supervisory duties you had.</b> <a href="#">More Info</a> If you need more space, use the Remarks tab. (1000 characters maximum)	
<div style="border: 1px solid #ccc; height: 40px; width: 100%;"></div> <div style="border: 1px solid #ccc; width: 100%; margin-top: 2px;"><div style="background-color: #ccc; width: 20%;"></div></div> <p>Characters remaining: XXXX</p>	
<b>In this job, did you use machines, tools, or equipment?</b> <input type="radio"/> Yes <input type="radio"/> No	
<b>List the machines, tools, and equipment you used regularly when doing this job and explain what you used them for.</b> <a href="#">More Info</a>	



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

Characters remaining: XXXX

**In this job, did you interact with coworkers, the general public, or anyone else?**

Yes    No

**Describe who you interacted with, the purpose of the interaction, how you interacted, and how much time you spent doing it per workday or workweek. [? More Info](#)**

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

Characters remaining: XXXX

**Tell us about lifting and carrying in this job. Explain what you lifted, how far you carried it, and how often you did it in a typical workday.**

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

Characters remaining: XXXX

**Select the heaviest weight lifted:**

--

**Select the weight frequently lifted (i.e., 1/3 to 2/3 of the workday):**

--

**Did this job expose you to any of the following?**  
Check all that apply.

- Outdoors
- Extreme heat (non-weather related)
- Extreme cold (non-weather related)
- Wetness
- Humidity
- Hazardous substances
- Moving mechanical parts
- High, exposed places
- Heavy vibrations
- Loud noise
- Other

**Tell us about the exposure(s) and how often you were exposed.**

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

Characters remaining: XXXX

**Explain how your current medical condition(s) would affect your ability to do this job.**  
If you need more space, use the Remarks tab. (1000 characters maximum)

Characters remaining: XXXX


---

NextPreviousSave & Exit

### 3.42. More Info - Task

## Task Description

Last reviewed or modified 12/04/2023



Examples of tasks include:


- Stocking shelves
- Greeting customers
- Scheduling appointments
- Maintaining records

[Close](#)

### 3.43. More Info - Supervisor

## Supervisor Examples

Last reviewed or modified 12/04/2023



Examples include:


- Evaluating job performance
- Making schedules
- Maintaining time records

[Close](#)

### 3.44. More Info - Equipment

## Equipment Examples

Last reviewed or modified 12/04/2023



Examples include:


- Computer
- Telephone
- Forklift
- Air compressor
- Meat Slicer

[Close](#)

### 3.45. More Info - Interaction

## Interaction Examples

Last reviewed or modified 12/04/2023




Examples include:

- Answering customer questions on the telephone for 5 hours per day
- Showing clients sale properties for 4 hours per day

[Close](#)

### 3.46. job001 - 3 - cw&sw - Job History



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification    Medical   Work/Education   Remarks   Review

### Work History for Cameron Ford

Since Sep 10, 2011, has <Claimant Name> had any earnings greater than \$1000 before tax in any month? Do not count sick leave, vacation, or disability pay.  
We may contact them for more information.  
 Yes    No

### Job Listing

List all the jobs that they had in the **five years** before they became unable to work. Start with their most recent job.

When selecting the number of jobs include:

- All job titles even if they were for the same employer
- Do not include jobs <Claimant Name> held for less than 30 calendar days
- Self-employment (e.g. ride-share driving, hair stylist)
- Work in a foreign country

Select the number of jobs they have had in the five years before they became unable to work:  
--

### Most Recent Job

**Job Title:**  
Example: Cashier

**Type of Business:**  
Example: Grocery store

**Start Date:**  
--     
Month   Year

**End Date:**

In this section...

- Work Status
- Work Activity
- Work History
- Education

-- Month	-- Year
<b>Hours per Day:</b>	
0 Hours	0 Minutes
<b>Days per Week:</b>	
[ ]	
<b>Rate of Pay:</b>	
\$ [ ] Amount	-- [ ] Frequency

### Job Details

**In a typical workday, about how many hours were they on their feet or seated?**

The hours/minutes for standing, walking, and sitting should equal the hours per day reported for this job. Do not include breaks and lunch.

**Did they stand and walk (combined)?**

Yes  No

**How long did they stand and walk (combined)?**

0  
 Hours

0  
 Minutes

**Did they sit?**

Yes  No

**How long did they sit?**

0  
 Hours

0  
 Minutes

**In a typical workday, did they do any of these tasks at their most recent job? If so, how long did you do it?**

The hours/minutes for these tasks should not exceed the hours per day reported for this job. This information tells us about the physical and mental requirements of their job.

**Did they stoop (i.e., bending down & forward at the waist)?**

Yes  No

**How long did they stoop?**

0  
 Hours

0  
 Minutes

**Did they kneel (i.e., bending legs to rest on knees)?**

Yes  No

**How long did they kneel?**

0  
 Hours

0  
 Minutes

**Did they crouch (i.e., bending legs & back down & forward)?**

Yes  No

**How long did they crouch?**

0  
 Hours

0  
 Minutes

**Did they crawl (i.e., moving on hands & knees)?**

Yes  No

**How long did they crawl?**

0  
 Hours

0  
 Minutes

**Did they use fingers to touch, pick, or pinch (e.g., using a mouse, keyboard, turning pages, or buttoning a shirt)?**

One Hand  Both Hands  No

**How long did they use fingers to touch, pick or pinch?**

0  
 Hours

0  
 Minutes

**Did they use hands to seize, hold, grasp, or turn (e.g., holding a large envelope, a small box, a...**

**How long did they use hands to hold, grasp, or turn?**



<b>hammer, or water bottle)?</b> <input type="radio"/> One Hand <input type="radio"/> Both Hands <input type="radio"/> No	<input type="text" value="0"/> <input type="text" value="0"/> Hours   Minutes
<b>Did they reach at or below the shoulder?</b> <input type="radio"/> One Arm <input type="radio"/> Both Arms <input type="radio"/> No	<b>How many hours did they reach at or below the shoulder?</b> <input type="text" value="0"/> <input type="text" value="0"/> Hours   Minutes
<b>Did they reach overhead (above the shoulder)?</b> <input type="radio"/> One Arm <input type="radio"/> Both Arms <input type="radio"/> No	<b>How long did they reach overhead?</b> <input type="text" value="0"/> <input type="text" value="0"/> Hours   Minutes
<b>Did they climb stairs or ramps?</b> <input type="radio"/> Yes <input type="radio"/> No	<b>How long did they climb stairs or ramps?</b> <input type="text" value="0"/> <input type="text" value="0"/> Hours   Minutes
<b>Did they climb ladders, ropes, or scaffolds?</b> <input type="radio"/> Yes <input type="radio"/> No	<b>How long did they climb ladders, ropes, or scaffolds?</b> <input type="text" value="0"/> <input type="text" value="0"/> Hours   Minutes
<b>For this job, describe in detail the tasks that they did in a typical workday.</b> <a href="#">More Info</a> If you need more space, use the Remarks tab. (1000 characters maximum)	
<div style="border: 1px solid #ccc; height: 40px; width: 100%;"></div> <hr/> <p>Characters remaining: 1000</p>	
<b>In this job, did they do any writing, complete reports, or perform any duties like this?</b> <input checked="" type="radio"/> Yes <input type="radio"/> No	
<b>Describe the type of report they wrote and how much time they spent on it per workday or workweek.</b> If you need more space, use the Remarks tab. (1000 characters maximum)	
<div style="border: 1px solid #ccc; height: 40px; width: 100%;"></div> <hr/> <p>Characters remaining: 1000</p>	
<b>In this job, did they supervise other people in this job?</b> <input type="radio"/> Yes <input type="radio"/> No	
<b>Describe who and what they supervised and what supervisory duties they had.</b> <a href="#">More Info</a> If you need more space, use the Remarks tab. (1000 characters maximum)	
<div style="border: 1px solid #ccc; height: 40px; width: 100%;"></div> <hr/> <p>Characters remaining: XXXX</p>	
<b>In this job, did they use machines, tools, or equipment?</b> <input type="radio"/> Yes <input type="radio"/> No	
<b>List the machines, tools, and equipment they used regularly when doing this job and explain what they used them for.</b> <a href="#">More Info</a>	

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

Characters remaining: XXXX

**In this job, did they interact with coworkers, the general public, or anyone else?**

Yes    No

**Describe who they interacted with, the purpose of the interaction, how they interacted, and how much time they spent doing it per workday or workweek. [More Info](#)**

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

Characters remaining: XXXX

**Tell us about lifting and carrying in this job. Explain what they lifted, how far they carried it, and how often they did it in a typical workday.**

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

Characters remaining: XXXX

**Select the heaviest weight lifted:**

--

**Select the weight frequently lifted (i.e., 1/3 to 2/3 of the workday):**

--

**Did this job expose them to any of the following?**  
Check all that apply.

- Outdoors
- Extreme heat (non-weather related)
- Extreme cold (non-weather related)
- Wetness
- Humidity
- Hazardous substances
- Moving mechanical parts
- High, exposed places
- Heavy vibrations
- Loud noise
- Other

**Tell us about the exposure(s) and how often they were exposed.**

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

Characters remaining: XXXX


**Explain how their current medical condition(s) would affect their ability to do this job.**  
If you need more space, use the Remarks tab. (1000 characters maximum)

Characters remaining: XXXX

---

NextPreviousSave & Exit

### 3.47. edu001 - 1 - Education



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification   Medical   Work/Education   Remarks   Review

### Education, Training, and Literacy for Cameron Ford

**Highest Grade Completed:**  
Select the highest level of school completed, including homeschooling, online education, and education received in another country.  
--

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

**School Name:**

**Location of school:**  
 United States [or U.S. Territory]    Other  
   --  
City/Town   State[Territory]

**Were you in special education?**  
 Yes    No

**The school where you were last in 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:**

**Location of School:**  
 United States [or U.S. Territory]    Other  
   --  
City/Town   State[Territory]

**Special Education Start Date:**

In this section...

- Work Status
- Work Activity
- Work History
- Education

Enter the date you started special education.

--    
 Month Year

**Special Education End Date:**

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

--    
 Month Year

Still in special education

**Last Grade You Were in Special Education:**

--

**Reason(s) for Special Education:**

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

Characters remaining: 1000

## Training

**Have you recieved any type of training (specialized job, trade, or vocational training)?**

Yes  No

**Name of Training Facility:**

**Phone Number:**

U.S.  International

10-digit Number

**Address:**

**Country:**

United States or U.S. Territory

**Street Address:**

Street Line 1:

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

**City/Town:**

**State/Territory:**

--

**ZIP Code:**

**Type of Program:**

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

Characters remaining: XXXX

**Date Completed (or scheduled to be completed):**  
Enter the approximate date when you completed the program.

--   
Month Year

### Literacy 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:**

**Reading:**  
In the language you identified above, can you read a simple message, such as a shopping list or short and simple notes?  
 Yes  No

**Writing:**  
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](#)

### 3.48. edu001 - 3 - Education



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification    Medical    Work/Education    Remarks    Review

### Education, Training, and Literacy for Cameron Ford

**Highest Grade Completed:**  
Select the highest level of school completed, including homeschooling, online education, and education received in another country.  
--

**Date Completed:**  
Enter the date when <Claimant Name> most recently completed a school year as close as they can remember.  
--     
Month   Year

**School Name:**

**Location of school:**  
 United States [or U.S. Territory]    Other  
   --  
City/Town   State/Territory

**Were they in special education?**  
 Yes    No

**The school where they were last in 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:**

**Location of School:**  
 United States [or U.S. Territory]    Other  
   --  
City/Town   State/Territory

In this section...

- Work Status
- Work Activity
- Work History
- Education

**Special Education Start Date:**

Enter the date they started special education.

--    
Month Year

**Special Education End Date:**

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

--    
Month Year

Still in special education

**Last Grade <Claimant Name> Was in Special Education:**

--

**Reason(s) for Special Education:**

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

Characters remaining: 1000

## Training

**Has <Claimant Name> received any type of training (specialized job, trade, or vocational training)?**

Yes  No

**Name of Training Facility:**

**Phone Number:**

U.S.  International

10-digit Number

**Address:**

**Country:**

United States or U.S. Territory

**Street Address:**

Street Line 1:

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

**City/Town:**

**State/Territory:**

--

**ZIP Code:**

**Type of Program:**

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



Characters remaining: XXXX

**Date Completed (or scheduled to be completed):**

Enter the approximate date when <Claimant Name> completed the program.

--

Month Year

### Literacy Information

**What written language does <Claimant Name> 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:**

**Reading:**

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

- Yes       No

**Writing:**

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


- Yes       No

**Next**

Previous

Save & Exit

### 3.49. rvw-001-1 - Review



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification    Medical    Work/Education   Remarks   Review

### Review Information for Cameron Ford

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

**In this section...**  
[Remarks](#)

Applicant Information

**Identification Information**  
Name: **Cameron Ford**  
Social Security Number: **\*\*\*-\*\*-0302**  
Date of Birth: **May 15, 1986**  
Gender: **Female**

**Contact Information**  
Mailing Address: **401 Rosemont Ave, Frederick, MD 21701**  
Primary phone number: **(410) 555 - 1234 ext. 1**  
Secondary phone number: **Not answered**  
Email Address: **email@domain.com**  
Confirm Email Address: **email@domain.com**

**Ability to Communicate in English**  
Speak English: **Yes**  
Read English: **Yes**  
Write English: **Yes**

**Other Names**  
Other Names used on Medical or Educational Records: **Yes**  
Other Name 1: **Name 1**  
Other Name 2: **Name 2**

Re-entry Number


The Re-entry Number is: **67995625**  
(The Re-entry Number cannot be edited)

**Medical**


<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> <b>Conditions</b></p> <hr/> <p><b>List of physical and mental conditions</b></p> <ol style="list-style-type: none"><li>1. <b>Migraines</b></li><li>2. <b>Shin splints</b></li><li>3. <b>Back injury</b></li></ol> <p>Preferred measurement units: <b>Centimeters and Kilograms</b></p> <p>Height: <b>163 centimeters</b></p> <p>Weight: <b>90 kilograms</b></p>
<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> <b>Other Contact</b></p> <hr/> <p>Provide another contact: <b>Yes</b></p> <p><b>Contact 1</b></p> <p>Name: <b>Name</b></p> <p>Relationship to applicant: <b>Family Member</b></p> <p>Address: <b>Same as applicant</b></p> <p>Daytime phone number: <b>Same as applicant</b></p> <p>Understand English: <b>Yes</b></p> <p>Provide a second contact: <b>Yes</b></p> <p><b>Contact 2</b></p> <p>Name: <b>Name</b></p> <p>Relationship to applicant: <b>Government Agency</b></p> <p>Address: <b>Same as applicant</b></p> <p>Daytime phone number: <b>Same as applicant</b></p> <p>Understand English: <b>Yes</b></p>
<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> <b>Doctor/Healthcare Provider 1</b></p> <hr/> <p><b>Doctor/Healthcare Provider Details</b></p> <p>Name: <b>Dr. Richard Kimble I</b></p> <p>Office Name: <b>Some clinic</b></p> <p>Address: <b>1208 York Road, Suite 100, Baltimore, MD, 21093</b></p> <p>Phone Number: <b>(410) 111-3333</b></p> <p><b>Treatment</b></p> <p>Date first seen: <b>March 2018</b></p> <p>Date last seen: <b>September 2021</b></p> <p>Date of next appointment: <b>April 2024</b></p> <p>Medical conditions treated: <b>Migraines, sinus problems</b></p>
<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> <b>Hospital/Clinic 1</b></p> <hr/> <p><b>Hospital/Clinic Details</b></p> <p>Name: <b>Seattle Grace Hospital</b></p> <p>Name of Healthcare Provider Treated By: <b>Dr. Dock Tor</b></p>

<p>Address: <b>1234 NE Pacific St, Seattle, Washington, 99999</b></p> <p>Phone Number: <b>(410) 111-3333</b></p> <p><b>Treatment</b></p> <p>Date first seen: <b>April 2018</b></p> <p>Date last seen: <b>October 2021</b></p> <p>Date of next appointment: <b>May 2024</b></p> <p>Medical conditions treated: <b>Migraines, sinus problems</b></p>
<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> <b>Test 1</b></p>
<p>Kind of Test: <b>EKG (Heart test)</b></p> <p>Date of Test: <b>October 2021</b></p> <p>Sent for Test by: <b>Dr. Dock Tor</b></p>
<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> <b>Medicine 1</b></p>
<p>Medicine: <b>Ibuprofen</b></p> <p>Reason: <b>Headache</b></p> <p>Prescribed by: <b>No one prescribed this medicine</b></p>
<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> <b>Other Medical Record 1</b></p>
<p>Name of Organization: <b>Medical org</b></p> <p>Phone Number: <b>(000) 000-0000</b></p> <p>Address: <b>Street, City, State, Zip</b></p> <p>Name of Contact Person: <b>Dr. Med Ical</b></p> <p>First Contact: <b>April 2018</b></p> <p>Last Contact: <b>October 2021</b></p> <p>Next Contact: <b>May 2024</b></p> <p>Claim number: <b>11111</b></p> <p>Reason for contact: <b>Had to</b></p>
<p><b>Work/Education</b></p>
<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> <b>Work Status</b></p>
<p>Currently working: <b>Yes</b></p>
<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> <b>Work Activity</b></p>
<p>Condition caused employer to make changes to work activity: <b>Yes</b></p> <p>When did the changes start: <b>January 1, 2015</b></p>
<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> <b>Work History</b></p>
<p>Earnings greater than \$1000 before taxes in any month since January 2015: <b>Yes</b></p> <p>Number of jobs in before unable to work: <b>1</b></p>

<p><b>Most Recent Job</b></p> <p>Job Title: <b>Security</b></p> <p>Type of Business: <b>Convention Center</b></p> <p>Start Date: <b>January 2014</b></p> <p>End Date: <b>January 2016</b></p> <p>Hours per Day: <b>9 Hours, 0 mintes</b></p> <p>Days per Week: <b>5</b></p> <p>Pay Amount: <b>\$20</b></p> <p>Pay Frequency: <b>Hourly</b></p> <p><b>Job Details</b></p> <p>Standing and walking (combined): <b>7 hours, 0 minutes</b></p> <p>Sitting: <b>2 hours, 30 minutes</b></p> <p>Stooping: <b>No</b></p> <p>Kneeling: <b>0 hours, 30 minutes</b></p> <p>Crouching: <b>No</b></p> <p>Crawling: <b>2 hours, 30 minutes</b></p> <p>Using fingers: <b>Both hands, 9 hours, 0 minutes</b></p> <p>Using hands: <b>One hand, 9 hours, 0 minutes</b></p> <p>Reach at or below shoulder: <b>One arm, 9 hours, 0 minutes</b></p> <p>Reach overhead: <b>No</b></p> <p>Climb stairs, or ramps: <b>No</b></p> <p>Climb ladders, ropes, or scaffolds: <b>No</b></p> <p>Job tasks: <b>Lots of info</b></p> <p>Writing or reports: <b>Yes</b></p> <p>Describe reports: <b>Report descriptions</b></p> <p>Supervise others: <b>Yes</b></p> <p>Describe Supervision: <b>Tell folks what to do</b></p> <p>Use machines, tools, or equipment: <b>Yes</b></p> <p>Describe the machines, tools, or equipment: <b>Heavy machinery</b></p> <p>Interact with others: <b>Yes</b></p> <p>Describe interactions: <b>My boss and customers</b></p> <p>Lifting and carrying description: <b>I did these a lot</b></p> <p>Heaviest weight lifted: <b>10 lbs</b></p> <p>Weight frequently lifted: <b>25 lbs</b></p> <p>Exposures: <b>Wetness, Humidity</b></p> <p>Exposure descriptions: <b>Went outside</b></p> <p>How conditions would affect ability to do this job: <b>Made it way harder</b></p>	
<span>Edit</span> <span>✔ Education</span>	
<p><b>Education</b></p> <p>Highest Grade Completed: <b>12th Grade</b></p> <p>Date Completed: <b>May 1, 2000</b></p> <p>School Name: <b>Ed Yucation</b></p>	

<p>Location of school: <b>City, State</b></p> <p>In special education: <b>Yes</b></p> <p>Same school as above: <b>No</b></p> <p>Special education school name: <b>Other School</b></p> <p>Special education school location: <b>City, State</b></p> <p>Special education school start date: <b>June 1999</b></p> <p>Special education school end date: <b>August 1999</b></p> <p>Still receiving special education:</p> <p>Last grade in special education: <b>11th Grade</b></p> <p>Reason for special education: <b>I got sent there</b></p> <p><b>Training</b></p> <p>Received any type of training: <b>Yes</b></p> <p>Name of Training Facility: <b>Training facility name</b></p> <p>Phone Number: <b>(000) 000-0000</b></p> <p>Mailing Address: <b>Street, City, State, Zip</b></p> <p>Type of Program: <b>A good one</b></p> <p>Date completed: <b>March 2003</b></p> <p><b>Literacy Information</b></p> <p>Written language used every day: <b>English</b></p> <p>If 'Other' is selected, please specify language:</p> <p>Reading language used every day: <b>Yes</b></p> <p>Writing language used every day: <b>Yes</b></p>
<p><b>Remarks &amp; Options</b></p> <p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> <b>Remarks</b></p> <hr/> <p>The following are your remarks: <b>These are my comments.</b></p>
<p> <b>You will not be able to change your information once you continue to Step 3.</b></p> <p>When you select "Accept &amp; Continue to Step 3" below, you will have completed Step 2. Please make sure that everything you provided is correct before you continue to Step 3.</p>
<p><input type="button" value="Accept &amp; Continue to Step 3"/> <input type="button" value="Previous"/> <input type="button" value="Save &amp; Exit"/></p>

### 3.50. rvw-001- 3 - Review



# Social Security

Official Website of the U.S. Social Security Administration

## Apply for Benefits

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

Identification    Medical    Work/Education   Remarks   Review

### Review Information for Cameron Ford

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

**In this section...**  
[Remarks](#)

Applicant Information

**Identification Information**  
Name: **Cameron Ford**  
Social Security Number: **\*\*\*-\*\*-0302**  
Date of Birth: **May 15, 1986**  
Gender: **Female**

**Contact Information**  
Mailing Address: **401 Rosemont Ave, Frederick, MD 21701**  
Primary phone number: **(410) 555 - 1234 ext. 1**  
Secondary phone number: **Not answered**  
Email Address: **email@domain.com**  
Confirm Email Address: **email@domain.com**

**Ability to Communicate in English**  
Speak English: **Yes**  
Read English: **Yes**  
Write English: **Yes**

**Other Names**  
Other Names used on Medical or Educational Records: **Yes**  
Other Name 1: **Name 1**  
Other Name 2: **Name 2**

Re-entry Number

The Re-entry Number is: **67995625**  
(The Re-entry Number cannot be edited)


**Medical**

<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> <b>Conditions</b></p> <hr/> <p><b>List of physical and mental conditions</b></p> <ol style="list-style-type: none"><li>1. <b>Migraines</b></li><li>2. <b>Shin splints</b></li><li>3. <b>Back injury</b></li></ol> <p>Preferred measurement units: <b>Centimeters and Kilograms</b></p> <p>Height: <b>163 centimeters</b></p> <p>Weight: <b>90 kilograms</b></p>
<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> <b>Other Contact</b></p> <hr/> <p>Provide another contact: <b>Yes</b></p> <p><b>Contact 1</b></p> <p>Name: <b>Name</b></p> <p>Relationship to applicant: <b>Family Member</b></p> <p>Address: <b>Same as applicant</b></p> <p>Daytime phone number: <b>Same as applicant</b></p> <p>Understand English: <b>Yes</b></p> <p>Provide a second contact: <b>Yes</b></p> <p><b>Contact 2</b></p> <p>Name: <b>Name</b></p> <p>Relationship to applicant: <b>Government Agency</b></p> <p>Address: <b>Same as applicant</b></p> <p>Daytime phone number: <b>Same as applicant</b></p> <p>Understand English: <b>Yes</b></p>
<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> <b>Doctor/Healthcare Provider 1</b></p> <hr/> <p><b>Doctor/Healthcare Provider Details</b></p> <p>Name: <b>Dr. Richard Kimble I</b></p> <p>Office Name: <b>Some clinic</b></p> <p>Address: <b>1208 York Road, Suite 100, Baltimore, MD, 21093</b></p> <p>Phone Number: <b>(410) 111-3333</b></p> <p><b>Treatment</b></p> <p>Date first seen: <b>March 2018</b></p> <p>Date last seen: <b>September 2021</b></p> <p>Date of next appointment: <b>April 2024</b></p> <p>Medical conditions treated: <b>Migraines, sinus problems</b></p>
<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> <b>Hospital/Clinic 1</b></p> <hr/> <p><b>Hospital/Clinic Details</b></p> <p>Name: <b>Seattle Grace Hospital</b></p> <p>Name of Healthcare Provider Treated By: <b>Dr. Dock Tor</b></p>



<p>Address: <b>1234 NE Pacific St, Seattle, Washington, 99999</b></p> <p>Phone Number: <b>(410) 111-3333</b></p> <p><b>Treatment</b></p> <p>Date first seen: <b>April 2018</b></p> <p>Date last seen: <b>October 2021</b></p> <p>Date of next appointment: <b>May 2024</b></p> <p>Medical conditions treated: <b>Migraines, sinus problems</b></p>
<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> Test 1</p>
<p>Kind of Test: <b>EKG (Heart test)</b></p> <p>Date of Test: <b>October 2021</b></p> <p>Sent for Test by: <b>Dr. Dock Tor</b></p>
<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> Medicine 1</p>
<p>Medicine: <b>Ibuprofen</b></p> <p>Reason: <b>Headache</b></p> <p>Prescribed by: <b>No one prescribed this medicine</b></p>
<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> Other Medical Record 1</p>
<p>Name of Organization: <b>Medical org</b></p> <p>Phone Number: <b>(000) 000-0000</b></p> <p>Address: <b>Street, City, State, Zip</b></p> <p>Name of Contact Person: <b>Dr. Med Ical</b></p> <p>First Contact: <b>April 2018</b></p> <p>Last Contact: <b>October 2021</b></p> <p>Next Contact: <b>May 2024</b></p> <p>Claim number: <b>11111</b></p> <p>Reason for contact: <b>Had to</b></p>
<p><b>Work/Education</b></p>
<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> Work Status</p>
<p>Currently working: <b>Yes</b></p>
<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> Work Activity</p>
<p>Condition caused employer to make changes to work activity: <b>Yes</b></p> <p>When did the changes start: <b>January 1, 2015</b></p>
<p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> Work History</p>
<p>Earnings greater than \$1000 before taxes in any month since January 2015: <b>Yes</b></p> <p>Number of jobs in before unable to work: <b>1</b></p>

<p><b>Most Recent Job</b></p> <p>Job Title: <b>Security</b></p> <p>Type of Business: <b>Convention Center</b></p> <p>Start Date: <b>January 2014</b></p> <p>End Date: <b>January 2016</b></p> <p>Hours per Day: <b>9 Hours, 0 mintes</b></p> <p>Days per Week: <b>5</b></p> <p>Pay Amount: <b>\$20</b></p> <p>Pay Frequency: <b>Hourly</b></p> <p><b>Job Details</b></p> <p>Standing and walking (combined): <b>7 hours, 0 minutes</b></p> <p>Sitting: <b>2 hours, 30 minutes</b></p> <p>Stooping: <b>No</b></p> <p>Kneeling: <b>0 hours, 30 minutes</b></p> <p>Crouching: <b>No</b></p> <p>Crawling: <b>2 hours, 30 minutes</b></p> <p>Using fingers: <b>Both hands, 9 hours, 0 minutes</b></p> <p>Using hands: <b>One hand, 9 hours, 0 minutes</b></p> <p>Reach at or below shoulder: <b>One arm, 9 hours, 0 minutes</b></p> <p>Reach overhead: <b>No</b></p> <p>Climb stairs, or ramps: <b>No</b></p> <p>Climb ladders, ropes, or scaffolds: <b>No</b></p> <p>Job tasks: <b>Lots of info</b></p> <p>Writing or reports: <b>Yes</b></p> <p>Describe reports: <b>Report descriptions</b></p> <p>Supervise others: <b>Yes</b></p> <p>Describe Supervision: <b>Tell folks what to do</b></p> <p>Use machines, tools, or equipment: <b>Yes</b></p> <p>Describe the machines, tools, or equipment: <b>Heavy machinery</b></p> <p>Interact with others: <b>Yes</b></p> <p>Describe interactions: <b>My boss and customers</b></p> <p>Lifting and carrying description: <b>I did these a lot</b></p> <p>Heaviest weight lifted: <b>10 lbs</b></p> <p>Weight frequently lifted: <b>25 lbs</b></p> <p>Exposures: <b>Wetness, Humidity</b></p> <p>Exposure descriptions: <b>Went outside</b></p> <p>How conditions would affect ability to do this job: <b>Made it way harder</b></p>	
<span>Edit</span> <span>✔ Education</span>	
<p><b>Education</b></p> <p>Highest Grade Completed: <b>12th Grade</b></p> <p>Date Completed: <b>May 1, 2000</b></p> <p>School Name: <b>Ed Yucation</b></p>	

<p>Location of school: <b>City, State</b></p> <p>In special education: <b>Yes</b></p> <p>Same school as above: <b>No</b></p> <p>Special education school name: <b>Other School</b></p> <p>Special education school location: <b>City, State</b></p> <p>Special education school start date: <b>June 1999</b></p> <p>Special education school end date: <b>August 1999</b></p> <p>Still receiving special education:</p> <p>Last grade in special education: <b>11th Grade</b></p> <p>Reason for special education: <b>I got sent there</b></p> <p><b>Training</b></p> <p>Received any type of training: <b>Yes</b></p> <p>Name of Training Facility: <b>Training facility name</b></p> <p>Phone Number: <b>(000) 000-0000</b></p> <p>Mailing Address: <b>Street, City, State, Zip</b></p> <p>Type of Program: <b>A good one</b></p> <p>Date completed: <b>March 2003</b></p> <p><b>Literacy Information</b></p> <p>Written language used every day: <b>English</b></p> <p>If 'Other' is selected, please specify language:</p> <p>Reading language used every day: <b>Yes</b></p> <p>Writing language used every day: <b>Yes</b></p>
<p><b>Remarks &amp; Options</b></p> <p><input type="button" value="Edit"/> <input checked="" type="checkbox"/> <b>Remarks</b></p> <hr/> <p>The following are your remarks: <b>These are my comments.</b></p>
<p> <b>You will not be able to change &lt;Claimant Name&gt;'s information once you continue to Step 3.</b></p> <p>When you select "Accept &amp; Continue to Step 3" below, you will have completed Step 2. Please make sure that everything you provided is correct before you continue to Step 3.</p>
<p><input type="button" value="Accept &amp; Continue to Step 3"/> <input type="button" value="Previous"/> <input type="button" value="Save &amp; Exit"/></p>



## 4. Appendix A - UXG Contact Information for Analysts, Developers and Others

For information about any of the content included in this design specifications document, contact the User Experience Group (UXG) Project Lead for this project and/or the appropriate project team member (for some projects a UXG designer may have specialized knowledge of one or more parts of the design).

To ensure a timely response to your inquiry in case of absence, please cc the UXG Team Lead.

<i>Name</i>	<i>Project Role</i>	<i>Email</i>	<i>Phone</i>	<i>Specialized Project Knowledge</i>
	UXG Team Lead			All
	UXG Project Lead			All
	UXG Designer			All
	UXG Designer			All