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**Request for Completion of Disability Forms**

Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

**1. The time frames and charges for completion of Disability forms are as follows:**

- A) Non-expedited completion of forms: 10 business days- \$15.00
- B) Expedited completion of forms: 5 business days- \$25.00

**2. Please make sure that any forms provided to our physicians are fully completed and signed.**

A) Any forms received that are not completed cannot be processed and the above time frames will not apply.

**3. Please list your occupation and a complete description of your job requirements:** (i.e. stands 8 hours, lift overhead 20lbs, kneeling, bending, etc). This will assist our physicians to identify what you will be able to appropriately and safely perform at your place of employment.

Occupation: \_\_\_\_\_

Job Requirements: \_\_\_\_\_

\_\_\_\_\_

Date completed information was dropped off: \_\_\_\_\_

Disability Dates: \_\_\_\_\_

Return to work date: \_\_\_\_\_

When form is completed ( ) Call me to pick up – (Tele #:) \_\_\_\_\_

( ) Fax to (Fax #:) \_\_\_\_\_

( ) Mail to: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I give my consent to have Upper Bucks Orthopaedics release my medical information to: (Please provide the name of the company that will have permission to review your medical information in regards to your disability forms)

Name of Company: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Once all of the above information is completed on this form, our staff will proceed in completing the Disability forms in the time frame listed above.