



**Treating Physician Information Form**

**\*\* This form may be completed by the Physician or the Claimant \*\***

Please complete a separate version of this form for each treating physician.

**Claimant Name:** \_\_\_\_\_

**VCF Claim Number:** VCF \_\_\_\_\_

**Physician Name:** \_\_\_\_\_

In the below chart, list the conditions for which the claimant is currently being (or previously was) treated by the physician. For each condition, provide the earliest date (month and year) of symptom onset and the date of first diagnosis (month and year).

Please provide copies of relevant records to support the diagnoses for the conditions listed below and any other information that might be relevant to the VCF, such as the effect of the condition(s) on the claimant. **Please refer to the "Diagnostic Essentials: Physical Health Conditions" document for the type of information that is required in order to verify a condition for compensation from the VCF.**

If applicable, please also provide a summary of any complications of treatment (i.e., new diagnoses stemming from treatment) and provide applicable medical records.

Condition Treated	Earliest Date of Symptom Onset (month/year)	Date of First Diagnosis (month/year)





**Treating Physician Contact Information**

**\*\* This form may be completed by the Physician or the Claimant \*\***

Please complete a separate version of this form for each treating physician.

**Claimant Name:** \_\_\_\_\_

**VCF Claim Number:** VCF \_\_\_\_\_

**Physician Name:** \_\_\_\_\_

**Physician Address:** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Physician Phone:** ( \_\_\_\_\_ ) \_\_\_\_\_

**Physician Fax:** ( \_\_\_\_\_ ) \_\_\_\_\_

**Physician Email:** \_\_\_\_\_

Please also provide the state(s) where the physician is licensed to practice medicine, the corresponding license number(s) and any practice specialties along with the corresponding AMA Physician Specialty Code.

**State(s) and license number(s):**

\_\_\_\_\_  
\_\_\_\_\_

**Specialties and AMA Physician Specialty Codes:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

