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:

_____

_____

_____