DISABILITY REPORT - ADULT
SSA-3368-BK

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

The information you give us on this report will be used by the office that makes the disability decision on your disability claim. Completing this report accurately and completely will help us expedite your claim. Please complete as much of the report as you can.

IF YOU NEED HELP

You can get help from other people, such as a friend or family member. Please do **not** ask your health care provider to complete this report. If you cannot complete the report, a Social Security Representative will assist you. If you have an appointment, please have the completed report ready when we contact you. If we ask you to do so, please mail the completed report to us ahead of time.

Note: If you are assisting someone else with this report, please answer the questions as if that person were completing the report.

HOW TO COMPLETE THIS REPORT

- Print or write clearly.
- Include a ZIP or postal code with each address.
- Provide complete phone numbers including area code. If a phone number is outside the United States, also provide International Direct Dialing (IDD) code and country code.
- If you cannot remember the names and addresses of your health care providers, you may be able to get that information from the telephone book, Internet, medical bills, prescriptions, or prescription medicine containers.
- **ANSWER EVERY QUESTION,** unless the report indicates otherwise. If you do not know an answer, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any question, please use Section 11 - Remarks on the last page to finish your answer. Write the number of the question you are answering.

YOUR MEDICAL RECORDS

If you have any of your medical records, send or bring them to our office with this completed report. Please tell us if you want to keep your records so we can return them to you. If you are having an interview in our office, bring your medical records, your prescription medicine containers (if available), and the completed report with you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will request your records. The information that you give us on this report tells us where to request your medical and other records.

WHAT WE MEAN BY "DISABILITY"

“Disability” under Social Security is based on your inability to work. For purposes of this claim, we want you to understand that “disability” means you are unable to work as defined by the Social Security Act. You will be considered disabled if you are unable to do any kind of work for which you are suited and if your disability is expected to last (or has lasted) for at least a year or is expected to result in death. So when we ask “when did you become unable to work,” we are asking when you became disabled as defined by the Social Security Act.

Privacy Act Statement
Collection and Use of Personal Information

Section 205(a), 223(d), and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to make a decision on the named claimant’s claim.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information could prevent us from making an accurate and timely decision on the named claimant’s claim.

We rarely use the information you supply for any purpose other than to make decisions regarding claims. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans’ Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal State, and local level; and,

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person’s eligibility for federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in Systems of Records Notice entitled, Claims Folders Systems, 60-0089. This notice, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 90 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO THE OFFICE THAT REQUESTED IT. You can find your local Social Security office through SSA’s website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778)**. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

AFTER COMPLETING THIS REPORT, REMOVE THIS SHEET AND KEEP IT FOR YOUR RECORDS

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0579

DISABILITY REPORT ADULT

For SSA Use Only- Do not write in this box.
Related SSN _____
Number Holder _____

Anyone who makes or causes to be made a false statement or representation of material fact for use in determining a payment under the Social Security Act, or knowingly conceals or fails to disclose an event with an intent to affect an initial or continued right to payment, commits a crime punishable under Federal law by fine, imprisonment, or both, and may be subject to administrative sanctions.

If you are filling out this report for someone else, please provide information about him or her. When a question refers to "you" or "your," it refers to the person who is applying for disability benefits.

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

1.A. Name (First, Middle Initial, Last)
Jane E. Doe

1.B. Social Security Number
123-45-6789

1.C. Mailing Address (Street or PO Box) Include apartment number or unit if applicable.
823 East Jackson Street

City	State/Province	ZIP/Postal Code	Country (If not USA)
Pensacola	FL	32501	

1.D. Email Address
support@ortizlawfirm.com

1.E. Daytime Phone Number, including area code, and the IDD and country codes if you live outside the USA or Canada.
Phone number (888) 888-8888

☐ Check this box if you do not have a phone or a number where we can leave a message .

1.F. Alternate Phone Number - another number where we may reach you, if any.
Alternate phone number (777) 777-7777

1.G. Can you speak and understand English? ☒ Yes ☐ No
If no, what language do you prefer? _____
If you cannot speak and understand English, we will provide an interpreter, free of charge.

1.H. Can you read and understand English? ☒ Yes ☐ No

1.I. Can you write more than your name in English? ☒ Yes ☐ No

1.J. Have you used any other names on your medical or educational records? Examples are maiden name, other married name, or nickname. ☒ Yes ☐ No
If yes, please list them here: Jane E. Smith

SECTION 2 - CONTACTS

Give the name of someone **(other than your doctors)** we can contact who knows about your medical conditions, and can help you with your claim.

2.A. Name (First, Middle Initial, Last)
John E. Doe

2.B. Relationship to you
Husband

2.C. Daytime Phone Number (as described in 1.E. above)
(888) 888-8888

2.D. Mailing Address (Street or PO Box) Include apartment number or unit if applicable.
823 East Jackson Street

City	State/Province	ZIP/Postal Code	Country (If not USA)
Pensacola	FL	32501	

2.E. Can this person speak and understand English? ☒ Yes ☐ No
If no, what language is preferred? _____

SECTION 2 - CONTACTS (continued)

2.F. Who is completing this report?

- ☒ The person who is applying for disability. (Go to Section 3 - Medical Conditions)
- ☐ The person listed in 2.A. (Go to Section 3 - Medical Conditions)
- ☐ Someone else (Complete the rest of Section 2 below)

2.G. Name (First, Middle Initial, Last)	**2.H.** Relationship to Person Applying

2.I. Daytime Phone Number _____

2.J. Mailing Address (Street or PO Box) Include apartment number or unit if applicable.

City	State/Province	ZIP/Postal Code	Country (If not USA)

SECTION 3 - MEDICAL CONDITIONS

3.A. List all of the physical or mental conditions (including emotional or learning problems) that limit your ability to work. If you have cancer, please include the stage and type. List each condition separately.

1. Back pain
2. Neck Pain
3. Anxiety
4. Depression
5. Stress

If you need more space, go to Section 11-Remarks on the last page

3.B. What is your height without shoes? 5 feet 5 inches OR _____ centimeters (if outside USA)

3.C. What is your weight without shoes? 140 pounds OR _____ kilograms (if outside USA)

3.D. Do your conditions cause you pain or other symptoms? ☒ Yes ☐ No

SECTION 4 - WORK ACTIVITY

4.A. Are you currently working?

- ☐ No, I have never worked (Go to question **4.B.** below)
- ☒ No, I have stopped working (Go to question **4.C.** below)
- ☐ Yes, I am currently working (Go to question **4.F.** on page 3)

IF YOU HAVE NEVER WORKED:

4.B. When do you believe your condition(s) became severe enough to keep you from working (even though you have never worked)? (month/day/year) _____ (Go to Section 5 on page 3)

IF YOU HAVE STOPPED WORKING:

4.C. When did you stop working? (month/day/year) 12/30/2019

Why did you stop working?

- ☒ Because of my condition(s).
- ☐ Because of other reasons. Please explain why you stopped working (for example: laid off, early retirement, seasonal work ended, business closed)

_____

Even though you stopped working for other reasons, when do you believe your condition(s) became severe enough to keep you from working? (month/day/year) _____

4.D. Did your condition(s) cause you to make changes in your work activity? (for example: job duties, hours, or rate of pay)

- ☒ No (Go to Section 5 - Education and Training on page 3)
- ☐ Yes When did you make changes? (month/day/year) _____

SECTION 4 - WORK ACTIVITY (continued)

4.E. Since the date in 4.D. above, have you had gross earnings greater than $1,090 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

☒ No (Go to Section 5) ☐ Yes (Go to Section 5)

IF YOU ARE CURRENTLY WORKING:

4.F. Has your condition(s) caused you to make changes in your work activity? (for example: job duties or hours)

☒ No When did your condition(s) first start bothering you? (month/day/year) 12/31/2019

☐ Yes When did you make changes? (month/day/year) _____

4.G. Since your condition(s) first bothered you, have you had gross earnings greater than $1,090 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

☒ No ☐ Yes

SECTION 5 - EDUCATION AND TRAINING

5.A. Check the highest grade of school completed.

0	1	2	3	4	5	6	7	8	9	10	11	12	GED	College: 1	2	3	4 or more
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐	☐

Date completed: 1988

5.B. Did you attend special education classes?

☐ Yes ☒ No (Go to 5.C.)

Name of School _____

City _____ State/Province _____ Country (If not USA) _____

Dates attended special education classes: from _____ to _____

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

☐ Yes ☒ No

If "Yes," what type? _____ Date completed: _____

If you need to list other education or training use Section 11 - Remarks on the last page.

SECTION 6 - JOB HISTORY

6.A. List the jobs (up to 5) that you have had in the 15 years before you became unable to work because of your physical or mental conditions. List your most recent job first.

☐ Check here and go to Section 7 on page 5 if you did not work at all in the 15 years before you became unable to work.

	Job Title	Type of Business	Dates Worked		Hours Per Day	Days Per Week	Rate of Pay	
			From MM/YY	To MM/YY			Amount	Frequency
1.	Registered Nurse	Healthcare	01/2000	12/2019	12	4	$71,000	Yearly
2.								
3.								
4.								
5.								

SECTION 6 - JOB HISTORY (continued)

Check the box below that applies to you.

☒ I had **only one job** in the last 15 years before I became unable to work. Answer the questions below.

☐ I had **more than one job** in the last 15 years before I became unable to work. Do **not** answer the questions on this page; go to Section 7 on page 5. (We may contact you for more information.)

Do not complete this page if you had **more than one job** in the last 15 years before you became unable to work.

6.B. Describe this job. What did you do all day?

Observe and record patient behavior, perform physical exams and diagnostic tests, collect patient health histories, counsel patients and their families, educate patients about treatment plans, administer medications, wound care, and other treatment options, interpret patient information and make decisions about necessary actions, consult with nurse supervisors and physicians to determine treatment plan, direct and supervise care of other healthcare professionals, including LPNs, certified nurse assistants, and nurse aides.

(If you need more space, use Section 11 - Remarks on the last page.)

6.C. In this job, did you:

Use machines, tools or equipment?	☒ Yes	☐ No
Use technical knowledge or skills?	☒ Yes	☐ No
Do any writing, complete reports, or perform any duties like this?	☒ Yes	☐ No

6.D. In this job, how many total hours each day did you do each of the tasks listed:

Task	Hours	Task	Hours	Task	Hours
Walk	8	Stoop *(Bend down & forward at waist.)*	1	Handle large objects	1
Stand	4	Kneel *(Bend legs to rest on knees.)*	1	Write, type, or handle small objects	1
Sit	0	Crouch *(Bend legs & back down & forward.)*	1	Reach	1
Climb	0.2	Crawl *(Move on hands & knees.)*	0		

6.E. Lifting and carrying *(Explain in the box below, what you lifted, how far you carried it, and how often you did this in your job.)*

I often had to lift patients or support their weight if they were unsteady on their feet. I also had to move heavy equipment such as hospital beds. I would frequently lift and/or move up to 20 pounds and occasionally lift or move 50 lbs, as well as assist with lifting weights of more than one-hundred (100) pounds

6.F. Check **heaviest** weight lifted:

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☒ 100 lbs. or more ☐ Other _____

6.G. Check weight **frequently** lifted: *(by frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 25 lbs. ☐ 50 lbs. or more ☒ Other 20 lbs.

6.H. Did you supervise other people in this job? ☒ Yes (Complete items below.) ☐ No (if No, go to **6.I.**)

How many people did you supervise? 5

What part of your time did you spend supervising people? 25%

Did you hire and fire employees? ☐ Yes ☐ No

6.I. Were you a lead worker? ☐ Yes ☒ No

SECTION 7 - MEDICINES

7. Are you taking any medicines (prescription or non-prescription)?

☒ Yes (Give the information requested below. You may need to look at your medicine containers.)

☐ No (Go to Section 8-Medical Treatment.)

Name of Medicine	If prescribed, give name of doctor	Reason for medicine
Xanax	Dr. Fraser	Anxiety
Zoloft	Dr. Fraser	Depression
Tramadol	Dr. Lee	Pain
Acetaminophen	OTC	Pain

If you need to list other medicines, go to Section 11 - Remarks on the last page.

SECTION 8 - MEDICAL TREATMENT

Have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or **do you have a future appointment scheduled**?

8.A. For any **physical** condition(s)?

☒ Yes ☐ No

8.B. For any **mental** condition(s) **(including emotional or learning problems)**?

☒ Yes ☐ No

If you answered "No" to both 8.A. and 8.B., go to Section 9 - Other Medical Information on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems). This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.C. Name of Facility or Office	Name of health care professional who treated you
Dynamic Pain and Wellness	Dr. Lee

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)
(444) 444-4444	

Mailing Address
1224 N Davis Highway

City	State/Province	ZIP/Postal Code	Country (If not USA)
Pensacola	FL	32505	

Dates of Treatment

1. Office, Clinic or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first	
First Visit January 6, 2020	A.	A. Date in	Date out
Last Visit May 6, 2020	B.	B. Date in	Date out
Next scheduled appointment (if any) July 6, 2020	C.	C. Date in	Date out

What medical conditions were treated or evaluated?

Back and neck pain

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)
Examinations, injections, and medications.

Check the boxes below for any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11-Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part)		☒ X-Ray (list body part) Spine	2020
☐ Hearing Test		☒ MRI/CT Scan (list body part) Spine	2020
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe)	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems). This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.D. Name of Facility or Office	Name of health care professional who treated you
Psychiatric Associates	Dr. Lee

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)
(222) 222-2222	

Mailing Address
4221 N Davis Highway

City	State/Province	ZIP/Postal Code	Country (If not USA)
Pensacola	FL	32505	

Dates of Treatment

1. Office, Clinic or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first	
First Visit 02/2020	A.	A. Date in	Date out
Last Visit 05/2020	B.	B. Date in	Date out
Next scheduled appointment (if any) 08/2020	C.	C. Date in	Date out

What medical conditions were treated or evaluated?

Anxiety, depression, stress

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)
Counseling, medications

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☒ **Check this box if no tests by this provider or at this facility.**

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part)		☐ X-Ray (list body part)	
☐ Hearing Test		☐ MRI/CT Scan (list body part)	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe)	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems). This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.E. Name of Facility or Office	Name of health care professional who treated you
Sacred Heart Hospital	

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first	
First Visit	A. 12/31/2019	A. Date in	Date out
Last Visit	B.	B. Date in	Date out
Next scheduled appointment (if any)	C.	C. Date in	Date out

What medical conditions were treated or evaluated?

Back and neck pain

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)
Examinations, evaluations, medications

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part)		☒ X-Ray (list body part) Spine	12/31/2019
☐ Hearing Test		☒ MRI/CT Scan (list body part) Spine	12/31/2019
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe)	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems). This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.F. Name of Facility or Office	Name of health care professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first	
First Visit	A.	A. Date in	Date out
Last Visit	B.	B. Date in	Date out
Next scheduled appointment (if any)	C.	C. Date in	Date out

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part)		☐ X-Ray (list body part)	
☐ Hearing Test		☐ MRI/CT Scan (list body part)	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe)	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems). This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.G. Name of Facility or Office	Name of health care professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first	
First Visit	A.	A. Date in	Date out
Last Visit	B.	B. Date in	Date out
Next scheduled appointment (if any)	C.	C. Date in	Date out

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part)		☐ X-Ray (list body part)	
☐ Hearing Test		☐ MRI/CT Scan (list body part)	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe)	
☐ Breathing Test			

If you have been treated by more than five doctors or hospitals, use Section 11 - Remarks on the last page and give the same detailed information as above for each healthcare provider.

SECTION 9 - OTHER MEDICAL INFORMATION

9. Does **anyone else** have medical information about your physical and/or mental condition(s) (including emotional and learning problems), or are you scheduled to see anyone else? (This may include places such as workers' compensation, vocational rehabilitation, insurance companies who have paid you disability benefits, prisons, attorneys, social service agencies and welfare.)

☐ Yes (Please complete the information below.)

☒ No (If you are receiving Supplemental Security Income (SSI) and have been asked to complete this report, go to Section 10 - Vocational Rehabilitation; if not, go to Section 11 on the last page.)

Name of Organization	Phone Number

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

Name of Contact Person	Claim or ID number (if any)

Date of First Contact	Date of Last Contact	Date of Next Contact (if any)

Reasons for Contacts

If you need to list other people or organizations use Section 11 - Remarks on the last page and give the same detailed information as above for each one you list.

COMPLETE THIS SECTION ONLY IF YOU ARE ALREADY RECEIVING SSI.
SECTION 10 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES

10.A. Have you participated, or are you participating in:

- An individual work plan with an employment network under the Ticket to Work Program;
- An individualized plan for employment with a vocational rehabilitation agency or any other organization;
- A Plan to Achieve Self-Support (PASS);
- An Individualized Education Program (IEP) through a school (if a student age 18-21); or
- Any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ Yes (Complete the following information) ☐ No (Go to Section 11)

10.B. Name of Organization or School

Name of Counselor, Instructor, or Job Coach	Phone Number

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

10.C. When did you start participating in the plan or program?

SECTION 10 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES (continued)

10.D. Are you still participating in the plan or program?

- ☐ Yes, I am scheduled to complete the plan or program on: _____
- ☐ **No.** I completed the plan or program on: _____
- ☐ **No.** I stopped participating in the plan or program before completing it because:

10.E. List the types of services, tests, or evaluations that you received (for example: intelligence or psychological testing, vision or hearing test, physical exam, work evaluations, or classes).

If you need to list another plan or program use Section 11 - Remarks and give the same detailed information as above.

SECTION 11 - REMARKS

Please write any additional information you did not give in earlier parts of this report. If you did not have enough space in the sections of this report to write the requested information, please use this space to tell us the additional information requested in those sections. Be sure to show the section to which you are referring.

Date Report Completed _____

month, day, year