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The Health Care Provider listed must submit all forms by mail, fax or email:

Disability Verification Form

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Life Activity	**Limitation on function**	**Degree of limitation:**
☐ A		☐ ☐ ☐
☐ A		☐ ☐ ☐
☐ B /		☐ ☐ ☐
☐ C /		☐ ☐ ☐
☐ C /		☐ ☐ ☐
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☐		☐ ☐ ☐
☐ D		☐ ☐ ☐
☐ C		☐ ☐ ☐
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Additional Comments/Questions:

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