Dear Doctor

I am applying for Social Security disability benefits, and I am in the process of preparing this case for a hearing before a Social Security Judge. As a treating physician your medical opinion *as well as your office notes*, and the results of any medial testing, are the key piece of evidence in Social Security's decision.

Accordingly, I would appreciate it very much if you would prepare an opinion letter which discusses my diagnosis (or diagnoses) in order of severity, the symptoms associated with those impairments. Work related limitations can be recorded on the Physical Capacity Evaluation form I have enclosed. ***Please send me a copy of the last 12 months of your office notes and results of any medical testing.***

Finally, please indicate whether you believe I am "disabled." "Disability", according to Social Security regulations, is defined as the inability to work eight hours per day, five days per week (or comparable schedule). It is well settled, for instance, that if an employee will miss, or is likely to miss, two to three days of work due to his or her impairments they will not be able to maintain employment. Your explicit opinion on these points would be invaluable.

Thank you for your cooperation in what I am sure is a burdensome task. If you have questions feel free to call.

Very truly yours,

PHYSICAL CAPACITY EVALUATION

Doctor's Name:

Claimant: Our File No.:

IMPORTANT: Please answer the questions and give limitations that you believe are imposed upon your patient referred to above. PLEASE KEEP IN MIND that we are asking you to assume in answering these questions with regard to limitations, a work setting where a person would be required to work eight hours a day, day after day, on a sustained and regular basis. If in your opinion there is a medical basis for claimant's pain, please consider that as a factor in this claimant's ability to do the following items.

I. In an 8 hour work day, your patient can stand/walk:

__ <1 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 Hours

II. In an 8 hour work day, your patient can sit:

___<1 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 Hours

III. Your patient can lift:

___0-5 lbs ___up to 10 lbs ___11-20 lbs ___21-50 lbs ___ over 51 lbs

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IV. Lifting as indicated in Item III can be performed during the work day:

___ None ___Occasionally ___Frequently ___Continuously

V. Can your patient can use hands for repetitive:

A. Simple grasping: ___ YES ___NO

B. Pushing and pulling: ___YES ___NO

C. Fine Manipulation: ___YES ___NO

VI. Can your patient use feet for repetitive movements as in operating foot controls:

___YES ___NO

VII. Your patient is able to:

A. Bend: ___ Frequently ___ Occasionally ___ Not at all
B. Squat: ___ Frequently ___ Occasionally ___ Not at all
C. Crawl: ___ Frequently ___ Occasionally ___ Not at all
D. Climb: ___ Frequently ___ Occasionally ___ Not at all

VIII: Diagnosis(es):

Onset date of TOTAL disability: _____

IX: Would your patient be able to function in spite of his/her medical condition(s) eight hours a day, day after day, without rest breaks in excess of that usually provided in the workplace (15 mins in the morning and afternoon, 30 min lunch break)?

_____YES _____NO

X: How many days per month would the your patient likely experience significant exacerbation of their condition that would cause them to be unable to leave their home for more than short periods of time?

____don't know ____0-1 ____2-4 ____5-10 ____10-15
____15+

XI: Note clinical findings and please comment on how your patient's medical conditions affect his/her ability to be employed in an 8 hour a day, day after day, work setting.

The opinions expressed above are based on first-hand knowledge of my patient's condition(s), experience treating patients with similar conditions, and are made with a reasonable degree of medical certainty.

_____ _____

DATE Physician Signature