TREATMENT/DISABILITY STATEMENT

INSTRUCTIONS FOR VICTIM/CLAIMANT: PLEASE DO NOT WRITE ON THIS FORM.
Give a copy of this form to each medical physician (Doctor, Dentist, Psychiatrist, Chiropractor) who provided treatment as a result of the crime incident. To be considered for treatment benefits, the victim must have suffered a physical injury as a result of the crime incident. This statement will be used to determine the compensable amount of wage loss or disability benefits.
INSTRUCTIONS FOR TREATMENT PROVIDER: Please complete and sign this form. You may fax or mail this original form directly to the Bureau of Victim Compensation. If requested by the victim/claimant, please provide them with a COPY of this information.

SECTION 1. Patient Information

1. Name of Patient:

2. Date of Birth: 3. Social Security #:

SECTION 2. Injury/Diagnosis

1. Type of Injury:

2. Diagnostic Code(s):

3. Time not able to work as a result of the crime. **Start Date:** **End Date:**

4. Will the patient require future treatment directly related to this injury? Yes ❒ No ❒
If yes, please explain:

SECTION 3. Disability

1. Did the patient suffer permanent disability as a result of the crime injury? Yes ❒ No ❒
If yes, please state the patient's permanent impairment to the body as a whole in accordance with the **AMA or FL Impairment Rating Guide.**
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SECTION 4. Physician Information

1. Name of Attending Physician:

2. Physician's Mailing Address:

City: State: Zip Code:

3. Physician's Telephone Number: ( )

4. Physician's Federal ID. #:

5. Physician's Signature: Date Signed:

Victim: **Claim Num: TLH**
BVC Analyst: **Crime Date:**