

## **Disabled Artists Foundation, Inc.**

For any questions, please email - Help@disabledARTISTS.org

## Disability Verification Form rev 1.1

Date: _	/20		
Please have your doctor fill out to provide proof of a patient's disability.			
Patient Information			
•	Full Name:		
•	Date of Birth:		
•	Address:	_	
•	Phone Number:	_	
•	Email:	-	
Medical Provider Information			
•	Provider Name:		
•	Medical License Number:		
•	Specialty:		
•	Office City:	State	
•	Phone Number:		



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## **Disability Information**

1.	Primary Diagnosis (Include ICD-10 Code):		
2.	Date of Diagnosis:		
3.	Secondary Conditions/Diagnoses (if any):		
4.	Is the condition expected to be permanent? $\ \square$ Yes $\ \square$ No		
5.	Duration of Disability:		
	Start Date: End Date (if temporary):		
6.	Nature of the Disability:		
Certifi	cation		
	ndersigned healthcare provider, certify that the information provided above is accurate at the patient named above is under my care for the listed condition(s) that result in ity.		
Provide	er Signature: Date:		
Provide	er Name:		