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: _____
- Email: _____

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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? □ Yes □ No
5. Duration of Disability:
   - Start Date: _____ End Date (if temporary): _____
6. Nature of the Disability:

Certification

I, the undersigned healthcare provider, certify that the information provided above is accurate and that the patient named above is under my care for the listed condition(s) that result in disability.

Provider Signature: _____ Date: _____

Provider Name: _____