# DISABILITY REPORT - ADULT
# SSA-3368-BK

## PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

The information you give us on this report will be used by the office that makes the disability decision on your disability claim. Completing this report accurately and completely will help us expedite your claim. Please complete as much of the report as you can.

## IF YOU NEED HELP

You can get help from other people, such as a friend or family member. Please do **not** ask your health care provider to complete this report. If you cannot complete the report, a Social Security Representative will assist you. If you have an appointment, please have the completed report ready when we contact you. If we ask you to do so, please mail the completed report to us ahead of time.

**Note**: If you are assisting someone else with this report, please answer the questions as if that person were completing the report.

## HOW TO COMPLETE THIS REPORT

- Print or write clearly.
- Include a ZIP or postal code with each address.
- Provide complete phone numbers including area code. If a phone number is outside the United States, also provide International Direct Dialing (IDD) code and country code.
- If you cannot remember the names and addresses of your health care providers, you may be able to get that information from the telephone book, Internet, medical bills, prescriptions, or prescription medicine containers.
- **ANSWER EVERY QUESTION,** unless the report indicates otherwise. If you do not know an answer, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any question, please use Section 11 - Remarks on the last page to finish your answer. Write the number of the question you are answering.

## YOUR MEDICAL RECORDS

If you have any of your medical records, send or bring them to our office with this completed report. Please tell us if you want to keep your records so we can return them to you. If you are having an interview in our office, bring your medical records, your prescription medicine containers (if available), and the completed report with you.

**YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE.** With your permission, we will request your records. The information that you give us on this report tells us where to request your medical and other records.

## WHAT WE MEAN BY "DISABILITY"

“Disability” under Social Security is based on your inability to work. For purposes of this claim, we want you to understand that “disability” means you are unable to work as defined by the Social Security Act. You will be considered disabled if you are unable to do any kind of work for which you are suited and if your disability is expected to last (or has lasted) for at least a year or is expected to result in death. So when we ask “when did you become unable to work,” we are asking when you became disabled as defined by the Social Security Act.

## The Privacy Act

Sections 205(a), 223(d), and 1631(e) (1) of the Social Security Act, as amended, authorize us to collect this information. The information you provide will be used to make a decision on the named claimant's claim. While giving us the information on this report is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. We generally use the information you supply for the purpose of making decisions regarding claims. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information about Social Security records (e.g., to the Government Accountability Office and the Department of Veterans Affairs); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and (4) to facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at **www.socialsecurity.gov** or at any local Social Security office.

## The Paperwork Reduction Act

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 60 minutes to read the instructions, gather the facts, and answer the questions.

**SEND OR BRING THE COMPLETED FORM TO THE OFFICE THAT REQUESTED IT.** If you do not have that address, you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). *You may send comments on our time estimate above to: SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

**AFTER COMPLETING THIS REPORT, REMOVE THIS SHEET AND KEEP IT FOR YOUR RECORDS**

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0579

# DISABILITY REPORT ADULT

**For SSA Use Only- Do not write in this box.**

**Related SSN** _____

**Number Holder** _____

**If you are filling out this report for someone else**, please provide information about him or her. When a question refers to "you" or "your," it refers to the person who is applying for disability benefits.

## SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

**1.A.** Name (First, Middle Initial, Last)

**1.B.** Social Security Number

**1.C.** Mailing Address (Street or P O Box) Include apartment number or unit if applicable.

| City | State/Province | ZIP/Postal Code | Country (If not USA) |
|---|---|---|---|
| | | | |

**1.D.** Email Address

**1.E.** Daytime Phone Number, including area code, and the IDD and country codes if you live outside the USA or Canada.

Phone number _____

☐ Check this box if you do not have a phone or a number where we can leave a message.

**1.F.** Alternate Phone Number - another number where we may reach you, if any.

Alternate phone number _____

**1.G.** Can you speak and understand English? ☐ YES ☐ NO

If no, what language do you prefer? _____

If you cannot speak and understand English, we will provide an interpreter, free of charge.

**1.H.** Can you read and understand English? ☐ YES ☐ NO

**1.I.** Can you write more than your name in English? ☐ YES ☐ NO

**1.J.** Have you used any other names on your medical or educational records? Examples are maiden name, other married name, or nickname. ☐ YES ☐ NO

If yes, please list them here:

## SECTION 2 - CONTACTS

Give the name of someone **(other than your doctors)** we can contact who knows about your medical conditions, and can help you with your claim.

**2.A.** Name (First, Middle Initial, Last)

**2.B.** Relationship to you

**2.C.** Daytime Phone Number (as described in 1.E. above)

_____

**2.D.** Mailing Address (Street or P O Box) Include apartment number or unit if applicable.

| City | State/Province | ZIP/Postal Code | Country (If not USA) |
|---|---|---|---|
| | | | |

**2. E.** Can this person speak and understand English? ☐ YES ☐ NO

If no, what language is preferred? _____

## SECTION 2 - CONTACTS (continued)

**2.F.** Who is completing this report?

- ☐ The person who is applying for disability. (Go to Section 3 - Medical Conditions)
- ☐ The person listed in 2.A. (Go to Section 3 - Medical Conditions)
- ☐ Someone else (Complete the rest of Section 2 below)

| **2.G.** Name (First, Middle Initial, Last) | **2.H.** Relationship to Person Applying |
|---|---|
| | |

**2.I.** Daytime Phone Number _____

**2.J.** Mailing Address (Street or P O Box) Include apartment number or unit if applicable.

| City | State/Province | ZIP/Postal Code | Country (If not USA) |
|---|---|---|---|
| | | | |

## SECTION 3 - MEDICAL CONDITIONS

**3.A.** List all of the physical or mental conditions (including emotional or learning problems) that limit your ability to work. If you have cancer, please include the stage and type. List each condition separately.

| |
|---|
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |

**If you need more space, go to Section 11 - Remarks on the last page**

**3.B.** What is your height without shoes? ____ feet ____ inches OR ____ centimeters (if outside USA)

**3.C.** What is your weight without shoes? ____ pounds OR ____ kilograms (if outside USA)

**3.D.** Do your conditions cause you pain or other symptoms? ☐ YES ☐ NO

## SECTION 4 - WORK ACTIVITY

**4.A.** Are you currently working?

- ☐ No, I have never worked (Go to question **4.B.** below)
- ☐ No, I have stopped working (Go to question **4.C.** below)
- ☐ Yes, I am currently working (Go to question **4.F.** on page 3)

**IF YOU HAVE NEVER WORKED:**

**4.B.** When do you believe your condition(s) became severe enough to keep you from working (even though you have never worked)? (month/day/year) _____ (Go to Section 5 on page 3)

**IF YOU HAVE STOPPED WORKING:**

**4.C.** When did you stop working? (month/day/year) _____

Why did you stop working?

- ☐ Because of my condition(s).
- ☐ Because of other reasons. Please explain why you stopped working (for example: laid off, early retirement, seasonal work ended, business closed) _____

Even though you stopped working for other reasons, when do you believe your condition(s) became severe enough to keep you from working? (month/day/year) _____

**4.D.** Did your condition(s) cause you to make changes in your work activity? (for example: job duties, hours, or rate of pay)

- ☐ No (Go to Section 5 - Education and Training on page 3)
- ☐ Yes When did you make changes? (month/day/year) _____

## SECTION 4 - WORK ACTIVITY (continued)

**4.E.** Since the date in 4.D. above, have you had gross earnings greater than $980 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

☐ No (Go to Section 5) ☐ Yes (Go to Section 5)

**IF YOU ARE CURRENTLY WORKING:**

**4.F.** Has your condition(s) caused you to make changes in your work activity? (for example: job duties or hours)

☐ No When did your condition(s) first start bothering you? (month/day/year) _____

☐ Yes When did you make changes? (month/day/year) _____

**4.G.** Since your condition(s) first bothered you, have you had gross earnings greater than $980 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

☐ NO ☐ YES

## SECTION 5 - EDUCATION AND TRAINING

**5.A.** Check the highest grade of school completed.

| | | | | | | | | | | | | | | College: | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | GED | 1 | 2 | 3 | 4 or more |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Date completed: _____

**5.B.** Did you attend special education classes? ☐ YES ☐ NO (Go to 5.C.)

Name of School _____

City _____ State/Province _____ Country (If not USA) _____

Dates attended special education classes: from _____ to _____

**5.C.** Have you completed any type of specialized job training, trade, or vocational school?

☐ YES ☐ NO

If "Yes," what type? _____ Date completed: _____

**If you need to list other education or training use Section 11 - Remarks on the last page.**

## SECTION 6 - JOB HISTORY

**6.A.** List the jobs (up to 5) that you have had in the 15 years before you became unable to work because of your physical or mental conditions. List your most recent job first.

☐ Check here and go to Section 7 on page 5 if you did not work at all in the 15 years before you became unable to work.

| Job Title | Type of Business | Dates Worked | | Hours Per Day | Days Per Week | Rate of Pay | |
|---|---|---|---|---|---|---|---|
| | | From MM/YY | To MM/YY | | | Amount | Frequency |
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |

## SECTION 6 - JOB HISTORY (continued)

**Check the box below that applies to you.**

☐ I had **only one job** in the last 15 years before I became unable to work. Answer the questions below.

☐ I had **more than one job** in the last 15 years before I became unable to work. Do **not** answer the questions on this page; go to Section 7 on page 5. (We may contact you for more information.)

**Do not** complete this page if you had **more than one job** in the last 15 years before you became unable to work.

**6.B.** Describe this job. What did you do all day? _____

_____

_____

**(If you need more space, use Section 11 - Remarks on the last page.)**

**6.C.** In this job, did you:

Use machines, tools or equipment? ☐ YES ☐ NO

Use technical knowledge or skills? ☐ YES ☐ NO

Do any writing, complete reports, or perform any duties like this? ☐ YES ☐ NO

**6.D.** In this job, how many total hours each day did you do each of the tasks listed:

| Task | Hours | Task | Hours | Task | Hours |
|---|---|---|---|---|---|
| Walk | | Stoop *(Bend down & forward at waist.)* | | Handle large objects | |
| Stand | | Kneel *(Bend legs to rest on knees.)* | | Write, type, or handle small objects | |
| Sit | | Crouch *(Bend legs & back down & forward.)* | | Reach | |
| Climb | | Crawl *(Move on hands & knees.)* | | | |

**6.E.** Lifting and carrying *(Explain in the box below, what you lifted, how far you carried it, and how often you did this in your job.)*

_____

_____

_____

_____

**6.F.** Check **heaviest** weight lifted:

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☐ 100 lbs. or more ☐ Other _____

**6.G.** Check weight **frequently** lifted: *(by frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 25 lbs. ☐ 50 lbs. or more ☐ Other _____

**6.H.** Did you supervise other people in this job? ☐ YES (Complete items below.) ☐ NO (if No, go to **6.I.**)

How many people did you supervise? _____

What part of your time did you spend supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

**6.I.** Were you a lead worker? ☐ YES ☐ NO

## SECTION 7 - MEDICINES

**7.** Are you taking any medicines (prescription or non-prescription)?

☐ YES (Give the information requested below. You may need to look at your medicine containers.)

☐ NO (Go to Section 8 - Medical Treatment.)

| Name of Medicine | If prescribed, give name of doctor | Reason for medicine |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**If you need to list other medicines, go to Section 11 - Remarks on the last page.**

## SECTION 8 - MEDICAL TREATMENT

Have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or **do you have a future appointment scheduled**?

**8.A.** For any **physical** condition(s)?

☐ YES ☐ NO

**8.B.** For any **mental** condition(s) **(including emotional or learning problems)**?

☐ YES ☐ NO

**If you answered "No" to both 8.A. and 8.B., go to Section 9 - Other Medical Information on page 11.**

## SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

| **8.C.** Name of Facility or Office | Name of health care professional who treated you |
|---|---|
| | |

**ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.**

| Phone Number | Patient ID# (if known) |
|---|---|
| | |

Mailing Address

| City | State/Province | ZIP/Postal Code | Country (If not USA) |
|---|---|---|---|
| | | | |

**Dates of Treatment**

| **1. Office, Clinic or Outpatient visits** | **2. Emergency Room visits** | **3. Overnight hospital stays** |
|---|---|---|
| First Visit _____ | List the most recent date first | List the most recent date first |
| Last Visit _____ | A. _____ | A. Date in _____ Date out _____ |
| Next scheduled appointment (if any) _____ | B. _____ | B. Date in _____ Date out _____ |
| | C. _____ | C. Date in _____ Date out _____ |

**What medical conditions were treated or evaluated?**

**What treatment did you receive for the above conditions?** (Do not describe medicines or tests in this box.)

Check the boxes below for any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests,use Section11 - Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

| Kind of Test | Dates of Tests | Kind of Test | Dates of Tests |
|---|---|---|---|
| ☐ EKG (heart test) | | ☐ EEG (brain wave test) | |
| ☐ Treadmill (exercise test) | | ☐ HIV Test | |
| ☐ Cardiac Catheterization | | ☐ Blood Test (not HIV) | |
| ☐ Biopsy (list body part) _____ | | ☐ X-Ray (list body part) _____ | |
| ☐ Hearing Test | | ☐ MRI/CT Scan (list body part) _____ | |
| ☐ Speech/Language Test | | | |
| ☐ Vision Test | | ☐ Other (please describe) _____ | |
| ☐ Breathing Test | | | |

**If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.**

## SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

| **8.D.** Name of Facility or Office | Name of health care professional who treated you |
|---|---|
| | |

**ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.**

| Phone Number | Patient ID# (if known) |
|---|---|
| | |

Mailing Address

| City | State/Province | ZIP/Postal Code | Country (If not USA) |
|---|---|---|---|
| | | | |

**Dates of Treatment**

| **1. Office, Clinic or Outpatient visits** | **2. Emergency Room visits** | **3. Overnight hospital stays** |
|---|---|---|
| First Visit _____ | List the most recent date first | List the most recent date first |
| Last Visit _____ | A. _____ | A. Date in _____ Date out _____ |
| Next scheduled appointment (if any) _____ | B. _____ | B. Date in _____ Date out _____ |
| | C. _____ | C. Date in _____ Date out _____ |

**What medical conditions were treated or evaluated?**

**What treatment did you receive for the above conditions?** (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

| Kind of Test | Dates of Tests | Kind of Test | Dates of Tests |
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| ☐ Cardiac Catheterization | | ☐ Blood Test (not HIV) | |
| ☐ Biopsy (list body part) _____ | | ☐ X-Ray (list body part) _____ | |
| ☐ Hearing Test | | ☐ MRI/CT Scan (list body part) _____ | |
| ☐ Speech/Language Test | | | |
| ☐ Vision Test | | ☐ Other (please describe) _____ | |
| ☐ Breathing Test | | | |

**If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.**

## SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

| **8.E.** Name of Facility or Office | Name of health care professional who treated you |
|---|---|
| | |

**ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.**

| Phone Number | Patient ID# (if known) |
|---|---|
| | |

Mailing Address

| City | State/Province | ZIP/Postal Code | Country (If not USA) |
|---|---|---|---|
| | | | |

**Dates of Treatment**

| **1. Office, Clinic or Outpatient visits** | **2. Emergency Room visits** | **3. Overnight hospital stays** |
|---|---|---|
| First Visit | List the most recent date first | List the most recent date first |
| Last Visit | A. | A. Date in Date out |
| Next scheduled appointment (if any) | B. | B. Date in Date out |
| | C. | C. Date in Date out |

**What medical conditions were treated or evaluated?**

**What treatment did you receive for the above conditions?** (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

| Kind of Test | Dates of Tests | Kind of Test | Dates of Tests |
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| ☐ Treadmill (exercise test) | | ☐ HIV Test | |
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| ☐ Biopsy (list body part) | | ☐ X-Ray (list body part) | |
| ☐ Hearing Test | | ☐ MRI/CT Scan (list body part) | |
| ☐ Speech/Language Test | | | |
| ☐ Vision Test | | ☐ Other (please describe) | |
| ☐ Breathing Test | | | |

**If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.**

## SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

| **8.F.** Name of Facility or Office | Name of health care professional who treated you |
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| | |

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|---|---|
| | |

Mailing Address

| City | State/Province | ZIP/Postal Code | Country (If not USA) |
|---|---|---|---|
| | | | |

**Dates of Treatment**

| **1. Office, Clinic or Outpatient visits** | **2. Emergency Room visits** | **3. Overnight hospital stays** |
|---|---|---|
| First Visit _____ | List the most recent date first | List the most recent date first |
| Last Visit _____ | A. _____ | A. Date in _____ Date out _____ |
| Next scheduled appointment (if any) _____ | B. _____ | B. Date in _____ Date out _____ |
| | C. _____ | C. Date in _____ Date out _____ |

**What medical conditions were treated or evaluated?**

**What treatment did you receive for the above conditions?** (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

| Kind of Test | Dates of Tests | Kind of Test | Dates of Tests |
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| ☐ Hearing Test | | ☐ MRI/CT Scan (list body part) _____ | |
| ☐ Speech/Language Test | | | |
| ☐ Vision Test | | ☐ Other (please describe) _____ | |
| ☐ Breathing Test | | | |

**If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.**

## SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

| **8.G.** Name of Facility or Office | Name of health care professional who treated you |
|---|---|
| | |

**ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.**

| Phone Number | Patient ID# (if known) |
|---|---|
| | |

Mailing Address

| City | State/Province | ZIP/Postal Code | Country (If not USA) |
|---|---|---|---|
| | | | |

**Dates of Treatment**

| **1. Office, Clinic or Outpatient visits** | **2. Emergency Room visits** | **3. Overnight hospital stays** |
|---|---|---|
| First Visit _____ | List the most recent date first | List the most recent date first |
| Last Visit _____ | A. _____ | A. Date in _____ Date out _____ |
| Next scheduled appointment (if any) _____ | B. _____ | B. Date in _____ Date out _____ |
| | C. _____ | C. Date in _____ Date out _____ |

**What medical conditions were treated or evaluated?**

**What treatment did you receive for the above conditions?** (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

| Kind of Test | Dates of Tests | Kind of Test | Dates of Tests |
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| ☐ Treadmill (exercise test) | | ☐ HIV Test | |
| ☐ Cardiac Catheterization | | ☐ Blood Test (not HIV) | |
| ☐ Biopsy (list body part) _____ | | ☐ X-Ray (list body part) _____ | |
| ☐ Hearing Test | | ☐ MRI/CT Scan (list body part) _____ | |
| ☐ Speech/Language Test | | | |
| ☐ Vision Test | | ☐ Other (please describe) _____ | |
| ☐ Breathing Test | | | |

**If you have been treated by more than five doctors or hospitals, use Section 11 - Remarks on the last page and give the same detailed information as above for each healthcare provider.**

## SECTION 9 - OTHER MEDICAL INFORMATION

**9.** Does **anyone else** have medical information about your physical and/or mental condition(s) (including emotional and learning problems), or are you scheduled to see anyone else? (This may include places such as workers' compensation, vocational rehabilitation, insurance companies who have paid you disability benefits, prisons, attorneys, social service agencies and welfare.)

☐ YES (Please complete the information below.)

☐ NO (If you are receiving Supplemental Security Income (SSI) and have been asked to complete this report, go to Section 10 - Vocational Rehabilitation; if not, go to Section 11 on the last page.)

| Name of Organization | Phone Number |
|---|---|
| | |

Mailing Address

| City | State/Province | ZIP/Postal Code | Country (if not USA) |
|---|---|---|---|
| | | | |

| Name of Contact Person | Claim or ID number (if any) |
|---|---|
| | |

| Date of First Contact | Date of Last Contact | Date of Next Contact (if any) |
|---|---|---|
| | | |

Reasons for Contacts

**If you need to list other people or organizations use Section 11 - Remarks on the last page and give the same detailed information as above for each one you list.**

## COMPLETE THIS SECTION ONLY IF YOU ARE ALREADY RECEIVING SSI.
## SECTION 10 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES

**10.A.** Have you participated, or are you participating in:

- An individual work plan with an employment network under the Ticket to Work Program;
- An individualized plan for employment with a vocational rehabilitation agency or any other organization;
- A Plan to Achieve Self-Support (PASS);
- An Individualized Education Program (IEP) through a school (if a student age 18-21); or
- Any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ YES (Complete the following information) ☐ NO (Go to Section 11)

**10.B.** Name of Organization or School

| Name of Counselor, Instructor, or Job Coach | Phone Number |
|---|---|
| | |

Mailing Address

| City | State/Province | ZIP/Postal Code | Country (if not USA) |
|---|---|---|---|
| | | | |

**10.C.** When did you start participating in the plan or program? _____

## SECTION 10 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES (continued)

**10.D.** Are you still participating in the plan or program?

☐ YES, I am scheduled to complete the plan or program on: _____

☐ NO. I completed the plan or program on: _____

☐ NO. I stopped participating in the plan or program before completing it because:

**10.E.** List the types of services, tests, or evaluations that you received (for example: intelligence or psychological testing, vision or hearing test, physical exam, work evaluations, or classes).

**If you need to list another plan or program use Section 11 - Remarks and give the same detailed information as above.**

## SECTION 11 - REMARKS

Please write any additional information you did not give in earlier parts of this report. If you did not have enough space in the sections of this report to write the requested information, please use this space to tell us the additional information requested in those sections. Be sure to show the section to which you are referring.

| **Date Report Completed** | ▶ | ☐☐ / ☐☐ / ☐☐☐☐<br>month, day, year |
|---|---|---|