AMERICAN OSTEOPATHIC ASSOCIATION

REDUCTION/WAIVER OF AOA ANNUAL MEMBERSHIP DUES: MEDICAL CONDITION

ATTENDING PHYSICIAN'S ASSESSMENT

Patient's Name: AOA ID:

Diagnosis:

Date of injury or illness:

Description

Present Status:

- ◯ Partial disability
- ◯ Total disability

What is the state of the disability? ◯ Temporary ◯ Permanent

If Temporary, how long? (weeks/months/year)

Prognosis:

In your opinion, will the patient be able to return to practice?

- ◯ Yes - Part-time
- ◯ Yes - Full-time
- ◯ No

In your opinion, when will the patient be able to return to practice?

Attending Physician's Signature: Date: