



MEDICAL CERTIFICATION OF TIME LOSS

Date of crime (mm/dd/yyyy)	Victim's name	Claim number
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Current mailing address	State	ZIP	Check if address is new <input type="checkbox"/>
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Last date worked	Date returned to work	Was sick leave or disability insurance paid? If yes, for what period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If not working, state why

Have you applied for or are you receiving benefits from:

Social Security
 Employment Security
 Public Assistance

	Date	Claimant's signature
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Provider's Statement (all questions must be answered)	Most recent treatment date	Is treatment concluded and the condition stable? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Has patient been released for work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date released	Will permanent impairment result from this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe
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Any physical and/or mental health restrictions?	If not released, when do you anticipate release for work?
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Remarks:

Date:	Print attending provider's name and title	Attending provider's signature
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TO CLAIMANT: Upon completion and return of this form, determination and payment of compensation for wage loss will be made if indicated.
NOTE: Persons making false statements in obtaining Crime Victim benefits are subject to civil or criminal penalties under the law.