VICTIM COMPENSATION TREATMENT DISABILITY STATEMENT

INSTRUCTIONS TO VICTIM/APPLICANT: PLEASE DO NOT WRITE ON THIS FORM. Give a copy of this form to each physician (Doctor, Dentist, Psychiatrist, Chiropractor) who provided medical treatment as a result of the crime.

INSTRUCTIONS TO TREATMENT PROVIDER: If you feel your patient meets the qualifications for a work excuse pursuant to s.440.12 and s.440.15, Fla. Stat., or if your patient suffered a permanent whole body disability as a result of the crime, please complete and sign this form. Consider only those injuries caused or exacerbated by the crime event when completing your evaluation. Send this form to the Office of the Attorney General, Bureau of Victim Compensation, PL-01, The Capitol, Tallahassee, FL 32399-1050, or by facsimile to (850) 414-6197 or (850) 414-5779, or email to VCIntake@MyFloridaLegal.com. Please provide a copy of this information to your patient.

SECTION ONE: PATIENT INFORMATION (please print)

1. Victim/Patient's Name (last, first, middle): _____
2. Date of Birth: _____/_____/_____ 3. Last Four Social Security Number: XXX-XX- _____

SECTION TWO: INJURY/DIAGNOSIS (please print)

1. Type of Injury Suffered: _____
2. Diagnostic Codes: _____

SECTION THREE: WORK EXCUSE (please print)

1. Is the patient excused from work as the result of crime injuries? ☐Yes ☐No ***(If no, skip to section four)***
2. Excuse Start Date: _____ 3. Excuse End Date: _____
4. Did a legal guardian miss work to provide immediate medical care to a minor victim/patient? ☐Yes ☐No ***(If no, skip to section four)***
5. Legal Guardian's Name, if patient is a minor (last, first, middle): _____
6. Start Date, if applicable: _____ 7. End Date, if applicable: _____

SECTION FOUR: PERMANENT DISABILITY ASSESSMENT (please print)

1. As a result of the crime, did the patient suffer a permanent impairment to the body as a whole? ☐Yes ☐No ***(If no, skip to section five)***
2. What is the permanent whole body disability rating expressed as a percentage? _____%
   (If this is a compound rating for multiple impairments, please specify a percentage for each functional loss.)
3. Has the patient reached Maximum Medical Improvement (MMI), or a percentage that will not change after MMI is reached?
   ☐Yes ☐No ***(If no, skip to section five)***
4. What resource was used for making this assessment?
   ☐Florida Impairment Rating Guide ☐American Medical Association Guide ☐Other (please specify): _____
5. Does the severity of the permanent impairment meet the definition of "catastrophic injury" as defined by s.960.03(1), Fla. Stat.?
   ☐Yes ☐No ***(If no, skip to section five)***
6. Please indicate which catastrophic qualification constitutes eligibility:
   - ☐Spinal cord injury involving severe paralysis of an arm, leg, or the trunk.
   - ☐Amputation of an arm, hand, foot, or leg.
   - ☐Severe brain or closed-head injury as evidenced by severe sensory or motor disturbances, severe communication disturbances, severe complex integrated disturbances of cerebral function, severe episodic neurological disorders, or other severe brain and closed head injury condition.
   - ☐Second-degree or third-degree burns on 25% or more of the total body surface or third-degree burns on 5% or more of the face and hands.
   - ☐Total or industrial blindness.
   - ☐Any other injury that is of a nature and severity that would qualify an employee to receive disability income benefits under Title II or supplemental security income benefits under Title XVI of the Federal Social Security Act.

SECTION FIVE: PHYSICIAN INFORMATION (please print)

1. Name of Attending Physician (last, first, middle): _____
2. Mailing Address: _____ 3. Email Address: _____
4. Telephone Number: _____ 5. Facsimile Number: _____
6. Federal Identification Number: _____ _____ 7. State Medical License Number: _____

BY SIGNING THIS FORM, I AFFIRM THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

8. Physician's Signature: _____ 9. Date: _____

Victim:	Claim Number:
BVC Analyst:	Crime Date: