PHILIP D. MURPHY
*Governor*

SHEILA Y. OLIVER
*Lieutenant Governor*

State of New Jersey
DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
P.O. BOX 951, TRENTON, NEW JERSEY 08625-0951

ROBERT ASARO-ANGELO
*Commissioner*

Claimant Name (first and last) Social Security Number:

Date:

## PHYSICIAN'S CERTIFICATION OF PERMANENT DISABILITY

In order to grant a waiver of recovery of your debt to this agency, this form must be completed by your personal physician and returned to the above address.

Please complete the section below before presenting this form to your physician.

Employer _____

Occupation _____ Last Day Worked _____

Note: The New Jersey Temporary Disability Benefits Program is not a "covered entity" under the Federal Health Information Portability and Accountability Act (HIPAA). All medical records of the Division, except to the extent necessary for the proper administration of the Unemployment Insurance Law are confidential and are not open to public inspection. The Division protects all records that may reveal the identity of the claimant or the nature or cause of the disability and the records may only be used in proceedings arising under the Law.

## PHYSICIAN'S STATEMENT

Date of Examination _____ Date Permanent Disability Began _____

1. History of the illness causing disability: _____

_____

_____

_____

2. Diagnosis: _____

_____

_____

_____

3. Your evaluation of the claimant's ability to work at any occupation. Explain in what way his/her symptoms or physical condition prevent him/her from working. _____

4. A. Is the claimant's disability likely to be stable or progressive? _____

B. Is it likely that he/she might improve to a degree that he/she could perform some type of work? If your reply is in the affirmative, please provide a projected date that the claimant could perform some type of work. _____

## CERTIFICATION

Please check the appropriate item which reflects your professional opinion:

- ❑ In my opinion, the claimant is totally and permanently disabled.
- ❑ In my opinion, the claimant is not totally and permanently disabled.

Signature _____ Date _____

Physician's Name _____

Address _____

Area of Specialization _____

License No. _____ State _____