

8. Please detail the patient's habits and his medical history that could increase the risk or contributed to his condition.

9. Was a surgery required or is to be expected? If yes, date and nature of the intervention.

10. Please detail the patient's habits about smoking, including according to your information and if so, how many the patient smoked cigarettes in the past and how many he smokes today.

11. Date of return to normal operations and / or physical and current mental limitations.

12. If you have other information of a medical nature that may help us in the evaluation of this request, please provide it.

Please include a copy of the file that you have COMPLETED for this person, including handwritten notes.

Name (print letters): _____ First name: _____

Address: _____

Telephone Number: _____ Specialty: _____

X _____
SIGNATURE DATE

Physician Stamp: