COLUMBIA COUNTY
Child Support

608-742-9610
FAX: 608-742-9823
http://www.dwd.state.wi.us/bcs

400 DeWitt Street
P.O. Box 256
Portage, WI 53901

Patient Name:_____ Diagnosis:_____

Date of Birth:_____ Date of injury/illness:_____

SSN:_____

Please select one of the following options:

1. ____ Patient is permanently and totally disabled as of _____ (date).

OR

2. ____ Patient is temporarily, totally disabled as of _____ (date) through _____ (date) and
   a) On _____ (date), patient will be re-evaluated.
   Or
   b) Patient has been referred to _____ for further treatment/opinion. Name/address/city/state/phone:
   _____
   _____
   _____

OR

3. ____ Patient is permanently, partially disabled and has the following work restrictions as of

   _____ (date), as follows/attached:
   _____
   _____
   _____

OR

4. ____ Patient is temporarily, partially disabled and has the following work restrictions as of _____(date), as follows/attached:_____ and will be re-evaluated on _____ (date) OR will be released to return to work without restrictions on _____ (date).

5.____ Patient has the ability to work full time.

Medical Physician's signature (no stamps):_____ Date:_____

Medical Physician's printed or stamped name: _____