Return to:

Attn:_____

Fax:_____

FAMILY INVESTMENT ADMINISTRATION
VERIFICATION OF DISABILITY

Name: _____ D.O.B. ___/___/___ Last 4 digits of SSN: _____

To verify disability/unable to work or participate in a work activity:

Section 1 must be completed/signed by the Customer.
Section 2 must be completed/signed by the Health Care Provider.

SECTION 1 – Customer:

☐ I am unable to work or participate in work activity because I have a physical or mental disability.

☐ I am pregnant.

Customer Signature: _____ **Date:** _____

SECTION 2 – Health Care Provider:

(Please print all the below) **Name of Provider:**			
Medical Group:			
Street Address/Suite:			
City, State, Zip:			
Provider's phone number:			
Provider's MD. License#:			
The named individual is unable to work or participate in a work activity until: (must indicate begin and end date – please do not use forever, indefinite, unknown for end date)		**Begin date:**	**End date:**

My signature verifies the person named above is unable to work or participate in a work activity for the period of time reported due to a disability.

Provider's Signature: _____ **Date**: _____

This form may be signed by any certified and licensed health care provider certified and licensed in Maryland providing health care to the named individual above. Acceptable non-physician health care providers include, but are not limited to: Licensed Clinical Social Workers (LCSW), midwives, Registered Nurse Practitioners (RNP), therapists, and acupuncturists.