



RHODE ISLAND DEPARTMENT OF LABOR AND TRAINING
TEMPORARY DISABILITY INSURANCE DIVISION

PO BOX 20100 CRANSTON, RHODE ISLAND 02920-0941
Tel.# for Physician offices only: (401) 462-8447 Tel.# for patients: 401-462-8420 FAX # (401) 462-8466

STATEMENT OF QUALIFIED HEALTHCARE PROVIDER (QHP)

(Physician or Medical Practitioner)

Printed from Website

Treating Physician or Medical Practitioner's Name:

Claimant's S.S. #: _____ - _____ - _____

Claimant's Name: _____

Customer's Address: _____

Treating Physician or Medical Practitioner's Address:

Customer's Phone #: _____

Email Address: _____

Date of Birth: ____/____/____

BELOW THIS LINE MUST BE COMPLETED BY A PHYSICIAN OR MEDICAL PRACTITIONER ONLY

If the above claimant is able to perform their regular and customary work while being treated for the current illness/injury and he/she does not have a job to return to, please indicate a recovery date. He/She may be eligible for Unemployment Insurance benefits.

- 1. Diagnosis (not symptoms): _____ ICD9-CM Code _____ (Required)
2. What are the functional limitations, if any, preventing him/her from performing customary work duties?
3. Cause of illness/injury: [] Work related [] Illness [] Pregnancy [] Auto accident [] Other:
4. Any Complications slowing recovery:
5. Provide date from which you are certifying he/she as functionally "unable to work".
6. Certifying examination date for current illness: Most recent examination date for current illness:
7. Was patient hospitalized for this illness/injury?
8. If Pregnancy, expected delivery date: Actual delivery date:
9. Is patient able to work pending surgery or delivery?
10. Based on the information provided, it is your medical opinion that, the above mentioned patient will be:

UNABLE TO WORK AS OF THIS DATE:(see #5) FOR THIS NUMBER OF WEEK(S): (How many weeks)

- 11. Is patient able to return to customary work on a full time basis?
12. Is patient able to return to less than his/her normal hour of work?
If yes, as of what date and for how many hours per day & week?
For how many weeks is patient able to work less than his/her normal hours?

Having considered the patient's regular and customary work, I certify under penalty of perjury that, based on my in-office examination, this medical certification truly describes the patient's disability (if any) and the estimated duration thereof. I also understand that if I make a false statement or fail to disclose facts, with intent to defraud the TDI Program, I shall upon conviction be punished to the full extent allowed by law including fine and /or imprisonment.

I further certify that I am a License #:
(Type of Qualified Healthcare Provider-QHP) (Specialty)

QHP's Name: Phone #: Fax#:

Signature: Date:

Please note: TDI is not responsible for costs incurred for copying medical records or completing medical forms. Any costs incurred is the responsibility of the claimant. Please mail to above address or fax to: (401) 462-8466