

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 FAX # (401) 462-8809
Telephone number for all patients (401) 462-8420

Fax of Impartial Examination Results

Date of Issue: 7/17/2013

Please complete and fax this within 24 hours of appointment or
within 15 days of issue date if claimant fails to make an appointment.

QHP Name
QHP Address

Patient's S.S. #:
Patient's Name:
Patient's Address:
Address:

DOB:

For Impartial Examiners - VIEW ONLY

Date of Examination: _____

It is my opinion that on the Date of Examination the claimant was/is able to work,
Performing the duties as described to me, for his/her occupation.

YES

NO

My complete report will follow within 10 days from the examination date.

Doctor's Signature

Date Signed

Fax to: Temporary Disability Insurance at 401-462-8809