Workers' Compensation Division
Department of Consumer and Business Services

PHYSICIAN AUTHORIZATION OF SUPPLEMENTAL DISABILITY

Worker: You are responsible for getting this form completed by your physician to continue receiving supplemental disability.

Worker

Worker name _____ Date of birth _____

Date of injury _____ Claim number _____ Primary insurer _____

Definitions:

- **Primary job** means the job at which the injury occurred.
- **Secondary job** means any other job held by the worker at the time of injury.
- **Temporary disability** means wage loss replacement for the primary job.
- **Supplemental disability** means wage loss replacement for the secondary job(s) that exceeds the temporary disability.

Physician

Physician's name (printed) _____ Phone number _____

Address _____ City _____ State _____ ZIP _____

Medically stationary?

☐ Yes (date): _____

☐ No (anticipated date): _____

Worker/patient ability to work:

☐ Regular work authorized start (date): _____

☐ Modified work authorized from (date): _____ through (date, if known): _____

☐ No work authorized from (date): _____ through (date, if known): _____

Restrictions:

I certify that these restrictions apply to :

☐ **Primary job**

☐ **Secondary job**

Physician's signature _____ Date _____