



Texas Police Trust
DISABILITY INCOME CLAIM FORM
1600 State St. Houston, Texas 77007

THIS SECTION TO BE COMPLETED BY CLAIMANT

Please Print

Payroll No. Social Security No.

Name of Patient Date of Birth

Patients Address

No. Street City State Zip Code

Home Phone Work Phone Pager

Injury Due To: Accident On-Duty Off-Duty

Description of Injuries:

I, hereby authorize releases of information requested on this form, by the below named physician for the purpose of processing this claim.

Signed Date

THIS SECTION TO BE COMPLETED BY ATTENDING PHYSICIAN

HISTORY

(a) When did symptoms first appear or accident happen? Month Day 20

(b) Date patient ceased work because of disability Month Day 20

(c) Has patient ever had same or similar condition? Month Day 20

(d) Is condition due to Injury Illness

PROGNOSIS

(a) Is patient now totally disabled? Yes No

(b) If yes, when will patient be able to return to work:

1 week 2-3 weeks 1 month 1-3 months 3-6 months never

(c) Please give a brief description of illness or injury:

Attending Physician

Name (Please Print) Signed Date

Address City State Zip Phone

THIS SECTION TO BE COMPLETED BY EMPLOYER

Was employee in active full-time employment when disability began? Yes No

If no, please explain

Is disability the sole cause of absence from work? Yes No

If no, please explain

Total Disability (unable to do any work): to present returned to work

Was disability due to an accident or illness arising out of or in the course of employment? Yes No

Comments: