EXCEPTIONALNURSE.COM
Medical Verification of Disability Form

Please have your physician or vocational rehabilitation counselor provide the following information. Upload this form with your application.

Name of Patient/Client: ____

Address: ____

City: ____

State: _____________________________________**Zip Code**_______________________

Verification of Disability

Diagnosis: ____

Prognosis____

Recommendations: ____
____
____
____

Name of Physician/ Nurse Practitioner/Counselor:
____

Address: ____

City: ____

State: ____________________________ **Zip Code**______________

Phone: __________________________________ **Email:** ___________________________

Print Name: ____

Signature: ___________________________________ **Date:** ______________________

Additional comments:
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