

In the Court of Common Pleas of **BUCKS** County, Pennsylvania

Phone:

Fax:

Member Name:  
Docket Number:  
PACSES Case Number:  
Other State ID Number:

Please note: All correspondence must include the PACSES Case Number.

**PHYSICIAN VERIFICATION FORM**

TO BE COMPLETED BY THE TREATING PHYSICIAN:

Physician's Name: \_\_\_\_\_

Physician's License Number: \_\_\_\_\_

Nature of patient's sickness or injury:  
\_\_\_\_\_  
\_\_\_\_\_

(a) Date of first treatment: \_\_\_\_\_

(b) Date of most recent treatment: \_\_\_\_\_

(c) Frequency of treatments: \_\_\_\_\_

(d) Medication: \_\_\_\_\_

The patient has had a medical condition that affects his or her ability to earn income from:

\_\_\_\_\_ through \_\_\_\_\_

If the patient is unable to work, when should the patient be able to return to work? Will there be limitations?

\_\_\_\_\_  
\_\_\_\_\_

REMARKS: \_\_\_\_\_

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Signature of Treating Physician

**I authorize my physician to  
release the above information to  
the \_\_\_\_\_ County  
Domestic Relations Section.**

\_\_\_\_\_  
Physician's Address

\_\_\_\_\_  
Physician's Telephone Number

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**

Form EN-015 09/17

Worker ID

Service Type

