



**Section 3 Income and Expenses**

**My Monthly Income**

**Student Loan Information**

* _____ Gross Wages	Type	Loan Amt	Mthly Pmt
* _____ Spouse's	_____	\$ _____	\$ _____
** _____ Public Assistance	_____	\$ _____	\$ _____
** _____ Unemployment	_____	\$ _____	\$ _____
** _____ Child Support	_____	\$ _____	\$ _____
** _____ Other Income	_____	\$ _____	\$ _____
** _____ Workmen Comp	_____	\$ _____	\$ _____
<b>\$ _____ Total</b>	<b>Total</b>	<b>\$ _____</b>	<b>\$ _____</b>

\*PLEASE FURNISH CHECK STUB      \*\*PLEASE FURNISH EVIDENCE

**Section 4 Statement of Disability (Completed by Physician)**

Patient's Name: \_\_\_\_\_ Subjective symptoms: \_\_\_\_\_  
 Relationship to Borrower: \_\_\_\_\_ Objective Symptoms: \_\_\_\_\_  
 Date when symptoms first appeared: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
 Date accident occurred: \_\_\_\_\_ **If needed please attach a separate sheet of paper**

**Treatment**

First visit date \_\_\_\_\_ Last visit date \_\_\_\_\_ Frequency of visit (Weekly, Monthly, Other) \_\_\_\_\_

**Progress**

Present condition: Recovered \_\_\_\_\_ Unchanged \_\_\_\_\_ Improved \_\_\_\_\_ Retrogressed \_\_\_\_\_  
 Is patient: Ambulatory \_\_\_\_\_ Bed Confined \_\_\_\_\_ House Confined \_\_\_\_\_ Hospital Confined \_\_\_\_\_

**Extent of Disability**

Is patient 'NOW' totally disabled for  
 If no, when is or was the patient able to go to work  
 Will patient be able to resume any work  
 Indefinite  
 Never

Any Occupation		Regular Occupation	
YES _____	NO _____	YES _____	NO _____
MM/DD/YY _____		MM/DD/YY _____	
MM/DD/YY _____		MM/DD/YY _____	
YES _____	NO _____	YES _____	NO _____
YES _____	NO _____	YES _____	NO _____

If yes, is patient a suitable candidate for rehabilitation Yes \_\_\_\_\_ No \_\_\_\_\_

Physician Name \_\_\_\_\_ Physician License Number \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Fax number \_\_\_\_\_ Date \_\_\_\_\_  
 Attending Physician Signature \_\_\_\_\_