NEUROLOGY CENTER OF FAIRFAX, LTD.

Fairfax Office 3020 Hamaker Ct, Suite 400, Fairfax, VA 22031
Reston Office 1830 Town Center Dr, Suite 305, Reston, VA 20190
Office Phone 703.876.0800 | Fax 703.876.0866
After hours emergency 703.755.1450

DISABILITY/WORK CAPACITY FORM

**If legal Guardian, a copy of Power of Attorney is required with this request

Name: _____ Date of Birth: _____

Date Symptoms Began: _____

Date Diagnosis Made: _____

Date Disability Began: _____

Diagnosis for Disability: _____

_____

_____

Last Day Worked: _____

If working part-time, date begun: _____
(Hours/Days or Days/Week)

Current Work Restrictions:_____

_____

_____

Employer/Job Title: _____

If you are not currently working, who certified work disability?_____

_____ When? _____

Short Term: _____ Long Term: _____

Why are you disabled? _____
(What can you not do?)

_____

_____

_____

_____

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NCF Disability/Work Capacity Form

Patient Name:_____ Date of Birth: _____

What aspects of your job can you not perform? _____

_____

_____

_____

_____

List cognitive/memory problems:_____

_____

_____

_____

_____

Additional Information:_____

_____

_____

_____

_____

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Guardian Date

_____
Printed Name

**If legal Guardian, a copy of the Power of Attorney must be attached.