SOVA: Physician's Disability Report – Lost Wages PSD26 Rev. 07/14

State Office of Victim Assistance: 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 Fax 803.734.2261

WWW.SOVA.SC.GOV **** Click on payment and reimbursement guide under the "For Providers" tab for more information

Criteria for Lost Wages

There are four criteria that must be met:
(1) Employment (2) Missed time from work (3) Reportable income & (4) Disability

Your Treating Physician must complete this form to confirm your inability to work as a direct result of the incident. Your Physician should return this form directly to our office by fax 803.734.2261 or US mail (see below for address). For questions, please contact us at 803.734.1900.

Legal name of (crime victim) injured patient_____

Social Security # (Last 5 digits) _____ Date of Birth ____/____/____

Date the patient (crime victim) was first seen by you in relation to the crime____/____/____

Date of crime related injury ____/____/____ (must be completed)

Briefly describe the injury/injuries sustained as a direct result of the crime:_____

_____

Treating Physician must provide a start and end date of the disability period

Patient will be totally unable to work from ____/____/____ through ____/____/_____

Check all that applies in accordance to the patient's physical ability:

- ☐ May resume work immediately without restrictions
- ☐ May resume work immediately with the following restrictions_____
  _____
- ☐ Patient may return to work at full capacity on (date) ____/_____/_____
- ☐ Patient may return to work at partial capacity on (date) ____/_____/_____
- ☐ Patient has a return appointment on (date) ____/_____/_____

Type or print Treating Physician's name_____ Phone (____) _____

Signature of Treating Physician_____ Date_____

Name and Address of Facility _____

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