Physician's/Medical Officer's Statement

Reset Print

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

OMB No. 1215-0173
Expires: 09-30-2011

The following statement is made in accordance with the Privacy Act of 1974, as amended (5 USC 552a). This report is authorized by Section 725-506 of the Black Lung Benefits Act, as amended (30 USC.922). While you are not required to respond, your cooperation will help us decide whether it would be in the patient's best interest to have his funds managed by another party. Your cooperation in completing and returning this statement will be appreciated. Please answer all items on this form.

Patient's (Beneficiary) Name

Patient's Social Security No.:

IDENTIFYING INFORMATION (DOL ONLY)

Miner's Name:

Patient's Date of Birth:

Patient's Address (Number and street, City, State and ZIP Code)

City

State Zip

Miner's Claim No.:

1. In your opinion, is the patient able to manage benefit payments in the patient's own interest?

☐ Yes (if "YES" or "UNDETERMINED," answer ONLY items 2 and 3 - then SIGN and DATE the form.)

☐ No (If "No," answer items 2 through 5 - then Sign and Date the form.)

☐ Undetermined

2. a. Describe the findings that led to this conclusion.

c. What type of impairment is this?

☐ Mental ☐ Physical

b. What is the diagnosis?

d. Date of Onset

3. What date did you last examine the patient?

Date of Examination

4. a. Do you expect this inability to manage funds to continue indefinitely?

☐ Yes ☐ No (if "No," answer 4b.) ☐ Undetermined

b. When do you expect the patient's ability to be restored?

5. If you know who has assumed responsibility for the patient, or who displays an active interest in the patient's welfare, please give that person's name, address, telephone number and relationship to the patient.

Name of person

Telephone Number (include Area Code)

Relationship to Patient

Address

City

State Zip

Whoever knowingly makes any false statement or misrepresentation of a material fact in an application or for use in determining a right to payment under the Federal Coal Mine Health and Safety Act, as amended, is subject to a fine or imprisonment, or both.

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS AND ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

Name of Physician/Medical Officer (Please print.)

Title

Address (Number and street, City, State, and ZIP Code) City State Zip

Telephone Number (include Area Code)

Signature of Physician/Medical Officer

Date

Public Burden Statement

We estimate that it will take an average of 15 minutes per response to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Division of Coal Mine Workers' Compensation, Room N-3464, 200 Constitution Avenue, N.W., Washington, D.C. 20210

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Form CM-787
May 1998

SEE REVERSE SIDE FOR INSTRUCTIONS AND TO MAKE REMARKS

6. REMARKS

INSTRUCTIONS:

PLEASE READ BEFORE COMPLETING FORM

The U.S. Department of Labor (DOL) requests your assistance in providing the information on this form. Please return the form as soon as possible to DOL in the envelope provided.

The information you give us will be used to determine whether your patient (or former patient), identified on the front of the form, has a mental or physical impairment which prevents the management of Black Lung benefits in that patient's best interests. If the patient is determined to be incapable of managing benefits, DOL will normally appoint a representative payee to receive and use benefits on behalf of the individual.

For DOL purposes, incapability means a beneficiary age 18 or older is dependent on others to provide protection of interests and daily needs -such as food, clothing and shelter. Examples of impairments causing incapability include severe mental retardation that has made the beneficiary dependent on others since birth, senility or forgetfulness resulting from advancing age, schizophrenia and other mental health problems and severe physical impairments that prevent the beneficiary from not only managing funds, but also directing others as to how to manage them.

The completed form should show the nature of the patient's impairment, if any, and, based on an examination conducted within the 1-year period prior to the date you complete this form, your opinion as to the patient's capability to manage monthly Black Lung benefit payments. If you have not examined the patient within the past year and if the patient has not made an appointment for an examination, please complete as many questions on the form as you deem advisable. We will use such information, along with other evidence we receive, to determine whether direct or representative payment will serve the patient's best interests.

Please sign and date the form before returning it.

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.