

# Continuing Disability Review Form

Full Name:

Social Security Number:

Date of Birth:

Address:

Phone Number:

## Medical Information

Describe your current disabling condition(s):

Treating Doctor's Name:

Clinic or Hospital Name:

Date of Most Recent Visit:

## Work and Activity Status

Have you worked since your last review?

- ☐ Yes  
☐ No

If yes, describe your work activities:

Submit