

## **MEDICAL SUFFICIENCY STATEMENT**

DATE

This letter is in support of the request for secondary dependency determination.

Patient's Name:

Patient's Date of Birth:

Patient's Age:

After reviewing his/her medical records it was determined that the medical condition existed prior to his/her 21st/23rd birthday.

- I. Diagnosis:
- II. Date of onset of medical condition (example: at birth, age 6 months, post-accident which occurred MMDDYYYY, etc.):
- III. Brief summary of condition (state whether the condition is a permanent or temporary disability. If condition is temporary, state anticipated time period that the condition might be resolved):
- IV. Level of incapacitation due to medical condition. Indicate patient's ability for self-support:
- V. Other facts regarding his/her medical status which may be deemed necessary:

Physician's Signature

Physician's Name

Address

Telephone