TDI-3 (Rev. 11/18)

RHODE ISLAND DEPARTMENT OF LABOR AND TRAINING

TEMPORARY DISABILITY INSURANCE DIVISION

P.O. Box 20100 Cranston, RI 02920

Tel. # (401) 462-8420 Fax # (401) 462-8466 TTY Via RI Relay 711

Statement of Qualified Healthcare Provider (QHP) - Physician

Please provide this form to the Qualified Healthcare Provider that is treating you

QHP Code: _____

QHP Please mail or fax within ten working days of: 08/24/23

SSN: XXX-XX-3619-24-1 DOB: 05/31/51

DOMENIC PASQUARELLI
POBOX14382
EAST PROVIDENCE, RI 02914

QHP Name:
Address: _____

Please provide this form to the Qualified Healthcare Provider that is treating you to complete the questions below

If the above claimant is <u>able to perform their regular and customary work</u> while being treated for the current illness/injury and he/she does not have a job to return to, please indicate a recovery date. He/She may be eligible for Unemployment Insurance benefits.

1. Diagnosis (not symptoms): _____ **ICD9-CM Code** _____ **(Required)**
2. Cause of illness/injury: ☐ Work related ☐ Illness ☐ Pregnancy ☐ Auto accident ☐ Other: _____
3. If illness/injury is work related, please indicate the <u>name of insurance carrier</u> being billed. _____
4. Any Complications slowing recovery: _____
5. Provide date closest to 08/13/23 that patient was examined for this illness/injury: __/__/____
6. Date of most recent examination date: __/__/____
7. Was patient hospitalized for this illness/injury? ☐ Yes ☐ No
   Hospital name: _____ Date Admitted: __/__/____ Date Discharged: __/__/____
8. Did patient have surgery? ☐ Yes ☐ No
   If yes, what type of surgery: _____ Date of surgery: __/__/
9. If Pregnancy, expected delivery date: __/__/____ Actual delivery date: __/__/____
   Type of delivery: ☐ Vaginal ☐ C-section
   Any pregnancy complications? Please check one: Pre☐ <u>or</u> Post Partum☐ <u>or</u> No Complications☐
   The complications are: _____
10. Is patient able to work pending surgery or delivery? ☐ Full time work ☐ Part time work ☐ No work
11. Based on the information provided, it is your medical opinion that, the above mentioned patient will be:
    FROM THE CLAIM'S EFFECTIVE DATE: 08/13/23 **PATIENT IS UNABLE TO WORK FOR:** ____ **WEEKS**
12. Is patient able to return to customary work on a full time basis? ☐ Yes ☐ No
    If yes, as of what date: __/__/____
13. Is patient able to return to less then his/her normal hours of work? ☐ Yes ☐ No
    If yes, as of what date and for how many hours per day & week? Date: __/__/____Hours/day:___ Hours/week:
    For how many <u>weeks</u> is patient able to work less than his/her normal hours?_____ Weeks

Having considered the patient's regular and customary work, I certify that based on my examination, this medical certification accurately describes the patient's illness/injury and the period of time (if any) the patient is unable to work. I certify under penalty of perjury the above statements are true. I understand that if I make any false statements or fail to disclose facts, with intent to defraud the TDI Program, I shall upon conviction be punished to the full extent allowed by law including fine and or imprisonment.

I further certify that I am a _____ (Type of Qualified Healthcare Provider (QHP)) - _____ (Specialty) License #: _____

QHP's Name: _____ Phone #: _____ Fax#: _____

Signature: _____ **Date:** _____

Please note: TDI is not responsible for costs incurred of copying medical records or completing medical forms. Any costs incurred are the responsibility of the claimant.

An Equal Opportunity Employer/Program. Auxiliary aids and services are available upon request for individuals with disabilities.