



129 West Fowlkes St., Suite 143  
Franklin, TN 37064

615-790-5815 phone  
615-790-5891 fax  
www.thearcwc.org

*Achieve with us.*

**Patient Name** \_\_\_\_\_

**D.O.B.** \_\_\_\_\_

**Diagnosis** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Is the patient considered disabled based on this diagnosis?**  
Yes or No

**Is the disability considered to be of lifelong duration?**  
Yes or No

**Doctor's Signature** \_\_\_\_\_

**Doctor's Printed Name** \_\_\_\_\_

**Address** \_\_\_\_\_

\_\_\_\_\_

**Date** \_\_\_\_\_

