Form Approved
OMB No. 0960-0316

CLAIMANT'S STATEMENT WHEN REQUEST FOR HEARING IS FILED AND THE ISSUE IS DISABILITY

Print, type or write clearly and answer all questions to the best of your ability. Complete answers will aid in processing the claim. IF ADDITIONAL SPACE IS NEEDED, ATTACH A SEPARATE STATEMENT TO THIS FORM.

CLAIMANT'S NAME	SOCIAL SECURITY NUMBER
WAGE EARNER (Leave blank if name is the same as the claimant's)	SOCIAL SECURITY NUMBER

PRIVACY ACT AND PAPERWORK ACT NOTICE: The Social Security Act (section 205(a), 702, 1631(e)(1)(A) and (B), and 1869(b)(1) and (c), as appropriate authorized the collection of information on this form. We will use the information on your recent activities, condition, medical treatment, and medications to help us decide if we need to obtain more information. You do not have to give it, but if you do not you may not receive benefits under the Social Security Act. We may give out the information on this form without your written consent if we need to get more information to decide if you are eligible for benefits or if a Federal law requires us to do so. Specifically, we may provide information to another Federal, State, or local government agency which is deciding your eligibility for a government benefit or program; to the President or a Congressman inquiring on your behalf; to an independent party who needs statistical information for a research paper or audit report on a Social Security program; or to the Department of Justice to represent the Federal Government in a court suit related to a program administered by the Social Security Administration.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

TIME IT TAKES TO COMPLETE THIS FORM

We estimate that it will take you about 15 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form. If you have comments or suggestions on this estimate, or on any other aspect of this form, write to the Social Security Administration, ATTN: Reports Clearance Officer, 1-A-21 Operations Bldg., Baltimore, MD 21235-0001, and to the Office of Management and Budget, Paperwork Reduction Project (0960-0316), Washington, D.C. 20503. **Send only comments relating to our estimate or other aspects of this form to the offices listed above. All requests for Social Security cards and other claims-related information should be sent to your local Social Security office whose address is listed in your telephone directory under the Department of Health and Human Services.**

1. Have you worked since _____ , the date your request for reconsideration was filed? *(If yes, describe the nature and extent of work.)* → ☐ Yes ☐ No

2. Has there been any change in your condition since the above date? *(If yes, describe the change.)* → ☐ Yes ☐ No

3. Have your daily activities and/or social functioning changed since the above date? *(If yes, describe the changes.)* → ☐ Yes ☐ No

4a. Have you been treated or examined by a physician (other than as a patient in a hospital) since the above date? *(If yes, complete the following.)* → ☐ Yes ☐ No

NAME OF PHYSICIAN	ADDRESS *(Include ZIP code)*
AREA CODE AND TELEPHONE NUMBER	
HOW OFTEN DO YOU SEE THIS PHYSICIAN	DATES YOU SAW THIS PHYSICIAN
REASON FOR VISIT	
TYPE OF TREATMENT RECEIVED *(Include drugs, surgery, tests)*	

4b. Have you seen any other physician since the above date? → ☐ Yes ☐ No
(If yes, show the following:)

NAME OF PHYSICIAN	ADDRESS *(Include ZIP code)*
AREA CODE AND TELEPHONE NUMBER	
HOW OFTEN DO YOU SEE THIS PHYSICIAN	DATES YOU SAW THIS PHYSICIAN

REASON FOR VISIT

TYPE OF TREATMENT RECEIVED *(Include drugs, surgery, tests)*

If you have seen other physicians since you filed your claim, attach a list of their names, addresses, dates and reasons for visits.

5. Have you been hospitalized, or treated at a clinic or confined in a nursing home or extended care facility for your illness or injury since the above date? → ☐ Yes ☐ No
(If yes, show the following:)

NAME OF FACILITY	ADDRESS *(Include ZIP code)*
PATIENT OR CLINIC NUMBER	
WERE YOU AN INPATIENT? (Stayed at least overnight) ☐ Yes ☐ No *If yes, show* →	DATES OF ADMISSIONS AND DISCHARGES
WERE YOU AN OUTPATIENT ☐ Yes ☐ No *If yes, show* →	DATES OF VISITS

REASON FOR HOSPITALIZATION, CLINIC VISITS, OR CONFINEMENT

TYPE OF TREATMENT RECEIVED *(Include drugs, surgery, tests)*

If you have been in other hospitals, clinics, nursing homes, or extended care facilities for your illness or injury, attach a list of the names, addresses, patient or clinic numbers, dates and reasons for hospitalization, clinic visits, or confinement.

6. Have you received medical or vocational services from a community agency since the above date? (If yes, indicate below the name, address and telephone number of the agency.) → ☐ Yes ☐ No

7. Are you now taking any prescription drugs or medications? *(If yes, list them below.)* → ☐ Yes ☐ No

NAME OF MEDICATION(S)	DOSAGE BEING TAKEN	NAME OF PHYSICIAN(S)

8. Are you now taking any nonprescription drugs or medications? *(If yes, list them below.)* → ☐ Yes ☐ No

NAME OF MEDICATION(S)	DOSAGE BEING TAKEN

9. Have you filed (or do you intend to file) for workers' compensation? → ☐ Yes ☐ No

(If you have filed for workers' compensation and have received an award, please bring a copy of the award notice, redemption order, or settlement to your hearing.)

ADDITIONAL SPACE (If needed)