Brown & Brown of New York Inc.
dba Fitzharris & Company
333 Earle Ovington Blvd. Suite 215
Uniondale, NY 11553
Phone: (516) 944-2823

Attending Physician Statement

Insured Dependent Child	Child's Birthday
Insured Parent	Group Policy #
Group Policy Holder (full legal name)	

I hereby authorize this undersigned Physician to release any information in the course of examining the child named above.

Date: ___/___/______ Signed: ________________________________
(Parent, if child is a minor or Incapable)

The insured is responsible for the completion of this form without expense to the company. You may mail this form directly to the current Administrator or Insurance Carrier. If additional space is needed for answers, please use the back of the form.

The child named above is suffering from:
( ) Physical disability, Describe below in detail
( ) Mental disability, Describe below in detail

Child's present condition is:
( ) Ambulatory ( ) Bed Confined ( ) House Confined ( ) Hospital Confined

Disability History:

A. Nature of disability? (describe fully)

B. Cause of disability?

C. Date on which disability began? (birth, or thereafter – specify date)

Beginning Date: _____/_____/______

D. Date on which you were first consulted?

E. Do you expect this to be permanent?

( ) Yes, please explain ______________________________

( ) No – please provide the date through which the disability is expected to continue: ______/_____/_____

F. What is your diagnosis?

G. Does this disability presently render the child incapable of self-sustaining employment?

H. Further Comments:

Date	Signature of Attending Physician	Degree	Telephone Number

Street Address	City/Town	State	Zip Code