HR 1, 2 (+/%)

Workstation _____

Vhe Texas A&M University System

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____________________________aaaaaaa_
Employee's Name

[ ][ ][ ] – [ ][ ] – [ ][ ][ ][ ]
Employee's UIN

____
Dependent Child's Hwn'Name

____
Relationship (child, stepchild, foster child...)

____
Dependent Child's Place of Residence/Address

____
Dependent Marital Status (M/S)

____
Dependent's Date of Birth (MM/DD/YYYY)

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NOTE: Any fee for the completion of this form is the responsibility of the patient.

Patient's Name ______________________________
Diagnosis (Be as detailed as possible)

If dependent child has ever been under observation, care or treatment related to the dependent's disability in any hospital, sanitarium, asylum or similar institution, please complete the following:

Name of hospital or institution: ______________________________

Number of days: _____________ Date of last treatment or care: ______________________

Treatment: (a) Date of first visit
(b) Frequency of visits: Weekly Monthly Other

Extent of Disability
(a) Is patient incapable of self-support because of this disability? Yes No

(b) disability has existed continuously since ______________________
(c) When do you think patient will be able to return to gainful employment?

Approximate date ____________________ Indefinite Never

Name of Physician ______________________________ Phone number ______________________

Address of Physician ______________________________

Physician's Signature ______________________________ Date ______________________

Date Stamp