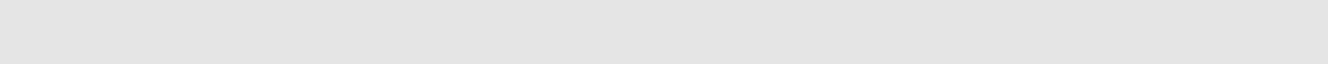


Verification of Permanent/Chronic Disability (Supplementary Information Requested)

Forms completed or altered by anyone other than the Certifying Medical Professional whose signature appears on this form will not be processed

STATE OF TEXAS, DEPARTMENT OF HEALTH, DIVISION OF EMPLOYMENT AND DISABILITY BENEFITS, DIVISION OF DISABILITY BENEFITS

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Symptom	Persists with treatment <input checked="" type="checkbox"/>	Frequency		
		Daily	Weekly	Monthly

