State of Nevada
Victims of Crime Program

Doctor's Certificate of Crime Related Disability

Submit in support of request for lost wage or income reimbursement due to crime related disability

Patient Information

Victim/Patient Name:	Last 4 Digits SSN:	VOCP Claim #

Physician Information:

Name of doctor who certified victim unable to work:	Phone#	Fax #

Doctors Mailing Address:	City, State, Zip:

Disability Information:

This patient has been under my care and treatment for his/her *crime injuries*:

From: _____ To: _____

At intervals of: Daily: _____ Weekly: _____ Monthly: _____ As Needed: _____

Have you restricted this patients work activity in any way because of his or her *crime injuries*?

No: ☐ Skip to the Doctor's Certification Below.

Yes: ☐ Enter Date Disability Began: _____/_____/_____ Enter Date Disability Ended: _____/_____/_____

If this patient is unable to return to work at this time, when do you anticipate releasing patient to return to work?

_____/_____/_____If unknown, please explain:

Diagnosis, objective findings, or statement of symptoms:

How does this injury prevent this patient from working?

Doctor's Certification and Signature:

Having considered the patient's regular or customary work, I certify under penalty of perjury that, based upon my examination, this Doctor's Certificate truly describes the patient's disability (if any) and the estimated duration thereof.

I further certify that I am a _____ *licensed to practice in the State of :* _____

(Type of Doctor or Specialty)

Original Signature of Attending Doctor: (Original Signature Required)	Date:

Mail to: VOCP 500 E. Warm Springs Rd., #100 Las Vegas, NV 89119	*Fax to:* *(702) 486-2825*	*Scan and email to:* vocp@dcfs.nv.gov

*must be updated every three months if not released to work