# State of Nevada
# Victims of Crime Program

*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 # |
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## Physician Information:

| Name of doctor who certified victim unable to work: | Phone# | Fax # |
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| Doctors Mailing Address: | City, State, Zip: |
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## 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: |
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| *Mail to:* VOCP<br>6171 W. Charleston Blvd., Bldg. 9<br>Las Vegas, NV 89146 | *Fax to:*<br>*(702) 486-2825* | *Scan and email to:*<br>vocp@dcfs.nv.gov |
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*must be updated every three months if not released to work