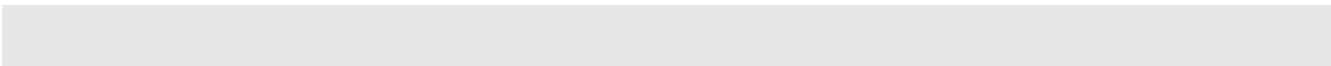


Verification of Permanent/Chronic Disability (Supplementary Information Requested)

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

[Redacted Signature Area]	
[Redacted]	[Redacted]



Symptom	Persists with treatment <input checked="" type="checkbox"/>	Frequency		
		Daily	+ee)ly	&onhly

