SOCIAL SECURITY ADMINISTRATION

Form Approved OMB No. 0960-0579

DISABILITY REPORT **ADULT**

For SSA Use Only- Do not write in this box. Related SSN Number Holder

If you are filling out this report					
SECTIO	N 1 - INFORMATION ABOUT	THE	ISABLED I	PER	RSON
1.A. Name (First, Middle Initial,			3. Social Se		
1.C. Mailing Address (Street or	P O Box) Include apartment nu	mber	or unit if app	olica	able.
City	State/Province	ZIP/P	ostal Code	T	Country (If not USA)
1.D. Email Address					
1.E. Daytime Phone Number, ir or Canada.	cluding area code, and the IDD	and o	country code	es li	you live outside the USA
Phone number					
Check this box if you do not have	e a phone or a number where we can	leave a	message .		
1.F. Alternate Phone Number -	another number where we may	reach	you, if any	,	
Alternate phone number					
1.G. Can you speak and under	stand English?		☐ YES		NO
lf no, what language do yo					
If you cannot speak and u	nderstand English, we will provi	de an	interpreter,	free	e of charge.
1.H. Can you read and understa	and English?		YES		NO
1.I. Can you write more than yo	ur name in English?		☐ YES		NO
1.J. Have you used any other n		ational		description	•
other married name, or nicknam	ne.		YES		NO
If yes, please list them here:					
	SECTION 2 - CON	TACT	5		
Give the name of someone (otle conditions, and can help you w	her than your doctors) we can ith your claim.	conta	act who know	ws a	about your medical
2.A. Name (First, Middle Initial,	Last)	2	.B. Relation	shi	p to you
2.C. Daytime Phone Number (a	s described in 1.E. above)				
2.D. Mailing Address (Street or	P O Box) Include apartment nu	ımber	or unit if ap	plica	able.
City	State/Province	ZIP/F	Postal Code		Country (If not USA)
2. E. Can this person speak an	d understand English?		YES		NO
If no, what language is p	referred?				
FORM SSA-3368-BK (12-2012) ef	(12-2012)				PAGE 1

3/24/2013 2:52 PM

	N 2 - CONTACTS (c	ontinued)	
2.F. Who is completing this report?			
☐ The person who is applying for disabilit			
The person listed in 2.A. (Go to Section		ons)	
Someone else (Complete the rest of Se	ection 2 below)		
2.G. Name (First, Middle Initial, Last)		2.H. Relationship to Pe	erson Applying
2.I. Daytime Phone Number			
2.J. Mailing Address (Street or P O Box) Inclu	ude apartment numb	er or unit if applicable.	
City State/Province	ce Z	ZIP/Postal Code Count	try (If not USA)
SECTIO	N 3 - MEDICAL CO	NDITIONS	
3.A. List all of the physical or mental condition to work. If you have cancer, please include the			
1.			
2.			
3.			
4.			
5.			
If you need more spa	ce, go to Section 11	-Remarks on the last	page
3.B. What is your height without shoes?	OR		
[eat		centimeters (if outside US	6A)
3.C. What is your weight without shoes?	OR		
	oounds	kilograms (if outside USA)	
3.D. Do your conditions cause you pain or oth	er symptoms?	YES NO	
	TION 4 - WORK ACT	TIVITY	
4.A. Are you currently working?			
☐ No, I have never worked (Go to ques			
☐ No, I have stopped working (Go to qu			
Yes, I am currently working (Go to qu	estion 4.F. on page 3	3)	
IF YOU HAVE NEVER WORKED: 4.B. When do you believe your condition(s) b have never worked)? (month/day/year)		h to keep you from wor Section 5 on page 3)	king (even though you
IF YOU HAVE STOPPED WORKING: 4.C. When did you stop working? (month/da Why did you stop working? Because of my condition(s). Because of other reasons. Please ex retirement, seasonal work ended, but	plain why you stoppe	d working (for example:	laid off, early
Even though you stopped working for condition(s) became severe enough 4.D. Did your condition(s) cause you to make job duties, hours, or rate of pay) No (Go to Section 5 - Education and Yes When did you make changes?	to keep you from wo changes in your wor Training on page 3)	rking? (month/day/year)	
FORM SSA-3368-BK (12-2012) ef (12-2012)			PAGE 2

		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		S	ECTIO	N 4 - V	VORK	ACTI	VITY	(contin	ued)	010 in =	any mon	th? Do	not	count
4.E.	Since the leave, v	e date in 4 acation, or	disabi	lity pa	y. (We	may c	ontact	you re	or mor	e illioili	natio	n.)	ary mon			
IF Y	OU ARE	CHOREN	TIVV	MORK	ING:											
4.F	Has you	r condition	n(s) cau	used y	ou to	make c	hange	es in yo	our wo	rk activ	ity?	for exam	nple: job	duties	or h	ours)
		No V	vhen di	d you	condi	tion(s)	first st	art bot	hering	you? (mon	th/day/ye	ar)			
		Yes V	Vhen di	id you	make	change	es? (m	onth/d	ay/yea	ar)				10 le es		
4.G	i. Since y	our condition to count s	ick lea	first bo we, va	ication	d you, h , or dis	ability	ou had pay. (d gross We m	s earnin ay cont	igs g act y	reater the	ore infor	mation	.)	
						15 - F	DUC	ATIC	N A	ND TR	AIN	IING				
5.	A. Che	ck the hig	hest										Co	llege:		20000000000000000000000000000000000000
n	1	2 3	4	5	6	7	8	9	10	11	12	GED	1	2 3	40	r more
D	ate con	pleted:														
5.	B. Did	you atten	nd spe	cial	educa	ation c	lasse	s?				/ES	□ NO) (Go to	5.0	:.)
	Nan	ne of Sch	lool													
C	ity				St	ate/Pr	ovino	e		Cour	ntry	(If not L	JSA)			
Date	es atter	ded spec	cial ec	ducat	ion cl	asses	:	from					to			
		you comp						ed job	traini	ing, tra	ide,	or voca	tional s	chool'	?	
	If "Yes,	" what ty	pe?							Date	Beeneedt	mpleted	Section 2			
	If	you need t	to list										***************************************	ast pag	je.	
		,								ISTOR						
6. <i>I</i>		he jobs (of your pl here and g	hypica	ol or r	ments	con	dition	SIIS	t vou	r most	rec	ent lon	mot.			to work e unable to
		Job Title				ype of		Da	ites V	Vorked		Hours Per	Days Per	R	ate	of Pay
					В	usines	5	Fro MM		To MM/		Day	Week	Amour	ıt	Frequency
4																
2.																
3.																
4.																
5.																
٥.																

FORM SSA-3368-BK (12-2012) ef (12-2012)

			TION 6 - JOE	3 HISTO	DRY (CC	ontinued	1)	
heck the	box belo	w that applies to	you.	hafara I	hanama	unable to v	work. Answer the question	ns below
	l had	only one job in th	e last 15 years	perore r	became	uttable to	TOTAL PROTECT STO GOODS	
	l had quest	more than one jo ions on this page;	b in the last 15 go to Section 7	years be on page	efore I be e 5. (We r	came unal nay conta	ole to work. Do not answ ot you for more information	er the n.)
o not co	mplete th	is page if you had	more than one	e job in t	he last 15	years be	fore you became unable	to work.
.B. Des	cribe thi	s job. What did	you do all d	ay?				
		(If you need mor	e space, use S	Section 1	11 - Rema	arks on th	e last page.)	
.C. In t	his job, o	did you:						
		tools or equipmen	t?		1	YES	□ NO	
		nowledge or skills				YES	□ NO	
		complete reports,		duties li	ke this?	☐ YES	□NO	

.D. In t	his job, l	how many total	hours each	day did	you do	each of	the tasks listed:	
Task	Hours	Task			Hours	Task		Hours
Walk		Stoop (Bend down	& forward at wai	ist.)			rge objects	
Stand Kneel (Bend legs to rest on knees.) Write, type, or handle small objects						3		
Sit		Crouch (Bend legs	& back down &	forward.)		Reach		
Climb		Crawl (Move on he	nds & knees.)					
	your job.						you carried it, and how of	
a.F. Ch	eck hea	viest weight lift	ed:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				000000000000000000000000000000000000000
	than 10 lb	posed 4.5.11	20 lbs.	☐ 50 I	bs.	100 lbs. o	or more	
6.G. Cl	neck wei	ght frequently	lifted: (by free	quently, v	we mean	from 1/3 to	2/3 of the workday.)	
Less	than 10 lb	os. 🔲 10 lbs.	☐ 25 lbs.	□ 50 I	bs. or mo	re 🗆	Other	
				job?	J YES (C	omplete iter	ns below.) NO (if No, g	o to 6.I.
How What	many peo	ple did you supen our time did you sp	vise? pend supervisin	ng people	?			
Did y	ou hire ar	nd fire employees?	YES [NO				
	ere you a	a lead worker?	YES [ON				

	SECTION 7 - MEDICINES	
. Are you taking any medicines (pres	scription or non-prescription)?	
YES (Give the information	n requested below. You may need to look at your n	nedicine containers.)
☐ NO (GotoSection8-Media	calTreatment.)	
Name of Medicine	Managed the declaration of the second	
Name of Medicine	If prescribed, give name of doctor	Reason for medicine
·		
If you need to list of	her medicines, go to Section 11 - Rem	arks on the last page.
SI	ECTION 8 - MEDICAL TREATMENT	
ve you seen a doctor or other health ve a future appointment schedule . For any physical condition(s)?	care professional or received treatment d?	at a hospital or clinic, or do yo
☐ YES ☐ NO		
For any mental condition(s) (inclu	ding emotional or learning problems)	?
if you ar Section s	nswered "No" to both 8.A. and 8.B., go 9 - Other Medical Information on page	o to 11.
RM SSA-3368-BK (12-2012) ef (12-2012)		PAGE 5

	SECTIO	ON 8 - MEDICA	L TRE	ATMENT	(continue	ed)		
Tell us who may have medical emotional or learning problems emergency room visits), clini have one scheduled.) that I	limit your ability	to wo	rk. This inc	ludes doc	tors' offic	es, hospital	ls (including
8.C. Name of Facility or Office	,			Name of h	nealth care	professi	ional who tr	eated you
ALL OF THE QUESTIO	NS ON	THIS PAGE R	EFER	TO THE	HEALTH (ARE PR	ROVIDER A	BOVE.
Phone Number				Patient ID	# (if know	n)		
Mailing Address								
City State/Province				ZIP/Postal Code Country (If not USA)				
Dates of Treatment				<u> </u>				
Office, Clinic or Outpatient vis First Visit	sits	2. Emergency List the most re					oital stays at date first	
Last Visit		A			A. Date in		Date out	
Next scheduled appointment (if an	v)	В			B. Date in	1	Date out	<u> </u>
	**	C.			C. Date in	n	Date out	t
Check the boxes below for any Please give the dates for past last page. Check this box if no test	tests	this provider per ture tests. If you	forme need	ed or sent y to list mor	you to, or l	nas sche	duled you to	o take.
Kind of Test	Da	ates of Tests		Kind	of Test		Dates o	of Tests
☐ EKG (heart test)			ΠE	EG (brain	wave test)			
☐ Treadmill (exercise test)			-	IV Test				
☐ Cardiac Catheterization			□В	lood Test ((not HIV)			
Biopsy (list body part)			□ ×	-Ray (list b	oody part)			
☐ Hearing Test				IRI/CT Scar	(list body	part)		
Speech/Language Test								
☐ Vision Test				ther (please	e describe)			
☐ Breathing Test								
If you do not have any	more	doctors or hos	spital	s to descr	ibe, go to	Section	9 on page	11.
FORM SSA-3368-BK (12-2012) ef	(12-201	2)		***************************************		***************************************		PAGE 6

t- Adult - ssa-3368.pdf				http)://w
SE	CTION 8 - MEDICA	AL TREATMEN	T (continu	ued)	
Tell us who may have medical re emotional or learning problems) to emergency room visits), clinics have one scheduled.	that limit your ability	to work. This is	ncludes do	ctors' offices hasnitals line	lu dir
8.D. Name of Facility or Office		Name o	f health ca	re professional who treated	you
ALL OF THE QUESTIONS	ON THIS PAGE F	REFER TO THE	HEALTH	CARE PROVIDER ABOVE	
Phone Number		Patient	D# (if knov	vn)	***************************************
Mailing Address			***************************************		
City	State/Province	ZIP/Post	al Code	Country (If not USA)	
Dates of Treatment					
Office, Clinic or Outpatient visits First Visit	2. Emergency List the most re	Room visits ecent date first	3. Overn List the n	ight hospital stays nost recent date first	
Last Visit	— A		A. Date li	Date out	
Next scheduled appointment (if any)	B		B. Date in	Date out	
***************************************	C		C. Date in	n Date out	
What medical conditions were	treated or evaluate	ed?			
What treatment did you receive for	the above condition	ns? (Do not desc	ribe medicin	es or tests in this box.)	•
Tell us about any tests this provid dates for past and future tests. If y	you need to list mor	re tests, use Se	s scheduled ction 11 - F	d you to take. Please give the Remarks on the last page.	10
Kind of Test	Dates of Tests	Kind	of Test	Dates of Tests	s
☐ EKG (heart test)		☐ EEG (brain	wave test)		
☐ Treadmill (exercise test)		☐ HIV Test			
Cardiac Catheterization	,	☐ Blood Test	(not HIV)		
☐ Biopsy (list body part)		☐ X-Ray (list	body part)		
☐ Hearing Test		MRI/CT Sca	n (list body	part)	
Speech/Language Test					
T Vision Test		Other (pleas	o describe)		

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

FORM **SSA-3368-BK** (12-2012) ef (12-2012)

☐ Breathing Test

	CTION 8 - MEDICAL	TREATMEN	T (continu	ed)
Tell us who may have medical re emotional or learning problems) i emergency room visits), clinics have one scheduled.	hat limit your ability	to work. This in	cludes do	ctors' offices, hospitals (including
8.E. Name of Facility or Office		Name of	health car	re professional who treated you
ALL OF THE QUESTION	S ON THIS PAGE R	EFER TO THE	HEALTH	CARE PROVIDER ABOVE.
Phone Number		Patient I	D# (if knov	vn)
Mailing Address				
City	State/Province	ZIP/Post	al Code	Country (If not USA)
Dates of Treatment				
1. Office, Clinic or Outpatient visit		Room visits		ight hospital stays
First Visit	List the most re-	cent date first		
Last Visit	— A		A. Date i	n Date out
Next scheduled appointment (if any)	В.		B. Date i	nDate out
rreat surround appointment (ii any)	ext scheduled appointment (if any) C.		C. Date i	n Date out
What medical conditions were	treated or avaluate	43	<u> </u>	
What treatment did you receive fo	r the above condition	s? (Do not desc	ribe medici	nes or tests in this box.)
Tell us about any tests this providates for past and future tests. If Check this box if no tests	you need to list more	e tests, use Se	ection 11 -	
dates for past and future tests. If	you need to list more	e tests, use Se at this facility.	ection 11 -	
dates for past and future tests. If ☐ Check this box if no tests	you need to list mor	e tests, use Se at this facility.	ction 11 -	Remarks on the last page. Dates of Tests
dates for past and future tests. If ☐ Check this box if no tests Kind of Test	you need to list mor	at this facility.	ction 11 -	Remarks on the last page. Dates of Tests
□ Check this box if no tests Kind of Test □ EKG (heart test)	you need to list mor	at this facility. Kind	oction 11 -	Remarks on the last page. Dates of Tests
dates for past and future tests. If ☐ Check this box if no tests Kind of Test ☐ EKG (heart test) ☐ Treadmill (exercise test)	you need to list mor	at this facility. Kind EEG (brain	I of Test wave test	Dates of Tests
Check this box if no tests Kind of Test EKG (heart test) Treadmill (exercise test) Cardiac Catheterization	you need to list mor	kind EEG (brain HIV Test Blood Test	of Test wave test (not HIV) body part)	Dates of Tests
Check this box if no tests Kind of Test EKG (heart test) Treadmill (exercise test) Cardiac Catheterization Biopsy (list body part)	you need to list mor	kind EEG (brain HIV Test Blood Test	I of Test wave test (not HIV) body part)	Dates of Tests
dates for past and future tests. If Check this box if no tests Kind of Test EKG (heart test) Treadmill (exercise test) Cardiac Catheterization Biopsy (list body part) Hearing Test	you need to list mor	kind EEG (brain HIV Test Blood Test	oction 11 - I of Test wave test (not HIV) body part)	Dates of Tests) part)

FORM SSA-3368-BK (12-2012) ef (12-2012)

8.F. Name of Facility or Office		Name o	f health care profe	essional who treated
ALL OF THE QUESTIO	ONS ON THIS PAGE F	REFER TO THE	HEALTH CARE	PROVIDER ABOVE
Phone Number		Patient	ID# (if known)	
Mailing Address				
City	State/Province	ZIP/Post	al Code Count	ry (If not USA)
Dates of Treatment				
Office, Clinic or Outpatient vi First Visit		Room visits ecent date first	3. Overnight ho List the most rec	spital stays ent date first
Last Visit	A		A. Date in	Date out
Last Visit	В.			
Next scheduled appointment (if an	(y) B. ———		B. Date in	Date out
				Data and
				Date out
What treatment did you receive Tell us about any tests this productes for past and future tests.	ere treated or evaluate for the above condition ovider performed or set. If you need to list more	ns? (Do not desc nt you to, or has re tests, use Se	ribe medicines or te s scheduled you to ction 11 - Remark	ests in this box.)
What treatment did you receive	ere treated or evaluate for the above condition ovider performed or set. If you need to list more	ns? (Do not desc nt you to, or has re tests, use Se at this facility.	ribe medicines or te s scheduled you to ction 11 - Remark	osts in this box.) to take. Please give the son the last page.
What treatment did you receive Tell us about any tests this prodates for past and future tests. Check this box if no test Kind of Test	ere treated or evaluate for the above condition ovider performed or se If you need to list months by this provider or	nt you to, or has re tests, use Se at this facility.	ribe medicines or te s scheduled you to ction 11 - Remark	ests in this box.)
What treatment did you receive Tell us about any tests this pro dates for past and future tests. Check this box if no test	ere treated or evaluate for the above condition ovider performed or se If you need to list months by this provider or	ns? (Do not desc nt you to, or has re tests, use Se at this facility.	ribe medicines or te s scheduled you to ction 11 - Remark	osts in this box.) to take. Please give the son the last page.
Kind of Test ☐ EKG (heart test)	ere treated or evaluate for the above condition ovider performed or se If you need to list months by this provider or	nt you to, or has re tests, use Se at this facility. Kind	s scheduled you to ction 11 - Remark of Test	osts in this box.) to take. Please give the son the last page.
What treatment did you receive Tell us about any tests this prodates for past and future tests. Check this box if no test Kind of Test EKG (heart test) Treadmill (exercise test)	ere treated or evaluate for the above condition ovider performed or se If you need to list months by this provider or	nt you to, or has re tests, use Se at this facility. Kind	s scheduled you to ction 11 - Remark of Test wave test)	osts in this box.) to take. Please give the son the last page.
What treatment did you receive Tell us about any tests this products for past and future tests. Check this box if no test Kind of Test EKG (heart test) Treadmill (exercise test) Cardiac Catheterization Biopsy (list body part)	ere treated or evaluate for the above condition ovider performed or se If you need to list months by this provider or	nt you to, or has re tests, use Se at this facility. Kind EEG (brain HIV Test Blood Test	s scheduled you to ction 11 - Remark of Test wave test) (not HIV) body part)	osts in this box.) to take. Please give the son the last page.
What treatment did you receive Tell us about any tests this productes for past and future tests. Check this box if no test Kind of Test EKG (heart test) Treadmill (exercise test) Cardiac Catheterization Biopsy (list body part) Hearing Test	ere treated or evaluate for the above condition ovider performed or se If you need to list months by this provider or	nt you to, or has re tests, use Se at this facility. Kind EEG (brain HIV Test Blood Test	s scheduled you to ction 11 - Remark of Test wave test)	osts in this box.) to take. Please give the son the last page.
Tell us about any tests this productes for past and future tests. Check this box if no test Kind of Test EKG (heart test) Treadmill (exercise test) Cardiac Catheterization Biopsy (list body part)	ere treated or evaluate for the above condition ovider performed or se If you need to list months by this provider or	nt you to, or has re tests, use Se at this facility. Kind EEG (brain HIV Test Blood Test X-Ray (list	s scheduled you to ction 11 - Remark of Test wave test) (not HIV) body part)	osts in this box.) to take. Please give the son the last page.
What treatment did you receive Tell us about any tests this products for past and future tests. Check this box if no test Kind of Test EKG (heart test) Treadmill (exercise test) Cardiac Catheterization Biopsy (list body part) Hearing Test Speech/Language Test	ere treated or evaluate for the above condition ovider performed or se If you need to list months by this provider or	nt you to, or has re tests, use Se at this facility. Kind EEG (brain HIV Test Blood Test	s scheduled you to ction 11 - Remark of Test wave test) (not HIV) body part)	osts in this box.) to take. Please give the son the last page.

ell us who may have medical re	ecords about any of ye	our physical a	nd/or mental condi	tion(s) (including
emotional or learning problems) imergency room visits), clinics have one scheduled.	that limit your ability t	o work. This in	cludes doctors' offic	es, nospitais (including
G.G. Name of Facility or Office		Name of	health care profess	ional who treated you
ALL OF THE QUESTION	S ON THIS PAGE RI	FER TO THE	HEALTH CARE PE	ROVIDER ABOVE.
Phone Number			O# (if known)	
Mailing Address				
City	State/Province	ZIP/Posta	Country	(If not USA)
Dates of Treatment				
1. Office, Clinic or Outpatient visi First Visit	its 2. Emergency I List the most re		3. Overnight hosp List the most recen	
	A		A . Date in	Date out
Last Visit	В.		B. Date in	Date out

Next scheduled appointment (if any	y)			
Next scheduled appointment (if any	C		C. Date in	Date out
Next scheduled appointment (if any What medical conditions were	C,	ed?	C. Date in	Date out
	C,	ed?	C. Date in	Date out
What medical conditions were	Ce treated or evaluate			
	Ce treated or evaluate			
What medical conditions were What treatment did you receive f	Ce treated or evaluate	ns? (Do not desc	ribe medicines or test	ts in this box.)
What medical conditions were What treatment did you receive f	ce treated or evaluate for the above condition	ns? (Do not desc	ribe medicines or test	ts in this box.)
What medical conditions were What treatment did you receive for Tell us about any tests this providates for past and future tests.	e treated or evaluate for the above condition vider performed or set If you need to list more	ns? (Do not desc nt you to, or ha re tests, use Se	ribe medicines or test s scheduled you to action 11 - Remarks	is in this box.)
What medical conditions were What treatment did you receive f	e treated or evaluate for the above condition vider performed or set If you need to list more	ns? (Do not desc nt you to, or ha re tests, use Se	ribe medicines or test s scheduled you to action 11 - Remarks	is in this box.)
What medical conditions were What treatment did you receive f Tell us about any tests this productes for past and future tests.	e treated or evaluate for the above condition vider performed or set If you need to list more	ns? (Do not desc nt you to, or ha re tests, use Se at this facility	ribe medicines or test s scheduled you to action 11 - Remarks	ts in this box.)
What medical conditions were What treatment did you receive for Tell us about any tests this providates for past and future tests. Check this box if no tests Kind of Test	ce treated or evaluate for the above condition vider performed or set If you need to list more solutions by this provider or	ns? (Do not desc nt you to, or ha re tests, use Se at this facility	s scheduled you to ection 11 - Remarks	ts in this box.) take. Please give the on the last page.
What medical conditions were What treatment did you receive for Tell us about any tests this providates for past and future tests. Check this box if no tests Kind of Test	ce treated or evaluate for the above condition vider performed or set If you need to list more solutions by this provider or	nt you to, or ha re tests, use Se at this facility.	s scheduled you to ection 11 - Remarks	ts in this box.) take. Please give the on the last page.
What medical conditions were What treatment did you receive for Tell us about any tests this providates for past and future tests. Check this box if no tests Kind of Test	ce treated or evaluate for the above condition vider performed or set If you need to list more solutions by this provider or	nt you to, or ha re tests, use Se at this facility. King	s scheduled you to ection 11 - Remarks	ts in this box.) take. Please give the on the last page.
What medical conditions were What treatment did you receive for the second and the second attention of	ce treated or evaluate for the above condition vider performed or set If you need to list more solutions by this provider or	nt you to, or have tests, use Seat this facility. Kind	s scheduled you to action 11 - Remarks d of Test n wave test)	ts in this box.) take. Please give the on the last page.
What medical conditions were What treatment did you receive for the second and the second attention and for the second attention and for the second attention and second attention are second attention as the second attention are second at the second attention attention at the second attention attention at the second atte	ce treated or evaluate for the above condition vider performed or set If you need to list more solutions by this provider or	nt you to, or have tests, use Seat this facility. Kind EEG (brain HIV Test Blood Test	s scheduled you to action 11 - Remarks d of Test n wave test)	ts in this box.) take. Please give the on the last page.
What medical conditions were What treatment did you receive for the second and the second attention and future tests. Check this box if no tests Kind of Test EKG (heart test) Treadmill (exercise test) Cardiac Catheterization Biopsy (list body part)	ce treated or evaluate for the above condition vider performed or set If you need to list more solutions by this provider or	nt you to, or have tests, use Seat this facility. Kind EEG (brain HIV Test Blood Test	s scheduled you to action 11 - Remarks d of Test n wave test) tt (not HIV) t body part)	ts in this box.) take. Please give the on the last page.
What medical conditions were What treatment did you receive for the state of the st	ce treated or evaluate for the above condition vider performed or set If you need to list more solutions by this provider or	nt you to, or have tests, use Seat this facility. Kind EEG (brain HIV Test Blood Test	s scheduled you to ection 11 - Remarks d of Test n wave test) t (not HIV) t body part)	ts in this box.) take. Please give the on the last page.

- Adult - 55a-	3308.pui							icep.
	SEC	TION 9 - OTHE	R ME	DICAL INFO	RMAT	NOF		
emotional and las workers' con	eaming problems), o	r are you sched al rehabilitation,	luled insu	to see anyon rance compa	e else?	(Th	al condition(s) (including its may include places ave paid you disability	such
YES	(Please complete the inf	formation below.)						
□ NO	(If you are receiving Sup Section 10 - Vocational I	plemental Security Rehabilitation, if not	Incom	e (SSI) and have Section 11 on the	e been a	sked i	to complete this report, go to)
Name of Organ	ization				Phone	Nu	mber	
Mailing Address	S				1			
City	ity State/Province			ZIP/Postal C	Code		Country (if not USA)	
Name of Conta	ame of Contact Person				er (if a	ny)		PARTICULAR DE LA CONTRACTOR DE LA CONTRA
Date of First Con	itact	Date of Last	t Cont	tact		Date	e of Next Contact (If any)	
Reasons for Co	ontacts							
If you need to	o list other people o same det	r organization ailed informati	s use	Section 11 s above for e	- Rema	arks ne y	on the last page and ou list.	give the
SECTION	COMPLETE THIS 10 - VOCATIONAL I	SECTION ONL	Y IF ON, I	YOU ARE AI	LREAD NT, OR	YR	ECEIVING SSI. HER SUPPORT SERV	ICES
 An indiv An indiv A Plan An Indiv Any pro 	to Achieve Self-Supp vidualized Education	n employment inployment with port (PASS); Program (IEP)	netwo a voo throu	cational rehab	oilitation	n age	ency or any other orga	
•	YES (Complete the		matic	on) 🔲 No	O (Go t	o Se	ection 11)	
10.B. Name of	Organization or Scho	ool						
Name of Couns	selor, instructor, or Jo	ob Coach			Pho	ne N	lumber	
Mailing Addres	S							<u> </u>
City		State/Province		ZIP/Postal	Code		Country (if not USA)	
10.C. When di	d you start participati	ng in the plan o	or pro	gram?				

3/24/2013 2:52 PM

PAGE 11

FORM SSA-3368-BK (12-2012) ef (12-2012)

SECTION 10 - VOCATION	AL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES (continued)
10.D. Are you still participating in	the plan or program?
YES, I am scheduled to compl	lete the plan or program on:
NO. I completed the plan or p	
NO. I stopped participating in	the plan or program before completing it because:
10.E. List the types of services, to testing, vision or hearing test, phy	ests, or evaluations that you received (for example: intelligence or psychologic ysical exam, work evaluations, or classes).
If you need to list anothe	er plan or program use Section 11 - Remarks and give the same detailed information as above.
	SECTION 11 - REMARKS
Please write any additional inform space in the sections of this report additional information requested in	nation you did not give in earlier parts of this report. If you did not have enough it to write the requested information, please use this space to tell us the in those sections. Be sure to show the section to which you are referring.
ate Report Completed	
are report completed	month, day, year

FORM **SSA-3368-BK** (12-2012) et (12-2012)