

**Participant Name**

**Birthdate**

(Print)

Date (dd/mm/yyyy)

America's Finest City Softball League's definition of disability: The inability to do any substantial gainful activity by reason of any medically determinable physical (except an injury that is not permanent) or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

## Evaluation Result

I find the above patient meets the AFCSL definition of disability and does not have a non-permanent injury.

I do not find the above patient meets the AFCSL definition of disability.

Signature of certified medical doctor or other legally certified medical provider

Date (dd/mm/yyyy)

**Medical Examiner's Name**

(Print)

**Clinical Degrees/Credentials**

**Clinic/Hospital**

**Address**

**Phone**

**Email**

Physician/Clinic Stamp (optional)

This form is valid until December 31st of the calendar year dated by the medical examiner.