STATE OF CALIFORNIA

DISABILITY STATEMENT FOR INCOME LOSS AUTHORIZATION

VCB-30-12733 (Rev. 05/2026)

CalVCB Application Number: _____

CalVCB may pay a victim or claimant for lost income caused by an injury from a crime. **If the victim is not permanently disabled, their doctor or mental health provider must give this information every 6 months.** For more details and instructions, please see the second page.

To be completed by the Treating Medical or Mental Health Provider

Victim's Name (Print): _____ Date of Injury: _____

Was this a crime-related injury? ☐ Yes ☐ No Was this a work-related injury? ☐ Yes ☐ No

Diagnosis With Code(s): _____

Prognosis: _____

Dates of Disability Period: From (mm/dd/yyyy) _____ to (mm/dd/yyyy) _____

6-month renewal? ☐ Yes ☐ No

Was the patient able to perform modified work-related duties during this time period? ☐ Yes ☐ No

If yes, please indicate the number of hours or percentage of time the patient is able to work per week:

Number of Hours: _____ or Percentage of Time: _____

Treating Medical or Mental Health provider certification and signature (REQUIRED): I certify under penalty of perjury that, my examination of the patient was within the scope of my licensure. Based upon this examination, I further attest that this Disability Statement accurately describes the patient's disability and the estimated period of disability, if any.

I further certify that I am licensed to practice in the state of _____ .

Printed Name of Treating Medical or Mental Health Provider
(as shown on license): _____

Professional License Number or NPI: _____

Treating Medical or Mental Health
Provider Address: _____ Phone Number: _____

Treating Medical or Mental Health Provider Signature: _____ Date: _____

Supervising Mental Health Provider Name: _____

State License Number: _____ Specialty: _____

Supervising Mental Health Provider Address: _____ Phone Number: _____

Supervising Mental Health Provider Signature: _____ Date: _____

Approved Providers for Physical Injuries:

- Medical Doctor
- Nurse Practitioner
- Physician Assistant
- Osteopath (DO)
- Optometrist
- Dentist
- Podiatrist
- Chiropractor (Only accepted for the period of time the provider is providing treatment)

Approved Providers for Emotional Injuries of 6 months or less:

- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Clinical Psychologist
- Licensed Psychiatrist
- Nurse Practitioner
- Physician Assistant

Disability statements submitted by out-of-state health care providers are acceptable if the medical or mental health providers licensure is comparable to the licensure of one of the authorized California medical or mental health providers.[1]

When the disability period of an emotional injury exceeds six (6) months, the disability statement must be completed by a treating licensed clinical psychologist or psychiatrist.

You can fax the completed document to CalVCB at 1-866-902-8669 or email it to documentreceivingsection@victims.ca.gov. State law requires that the information requested by CalVCB be sent back within 10 business days.[2]

1 Cal. Code Regs., tit. 2, § 649.32(c)(2)
2 Gov. Code, § 13954(a)