CONTINUING DISABILITY REVIEW REPORT
SSA-454-BK

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

The office that reviews your medical condition will use the information in this report. The information will help that office decide whether you are still disabled. Please complete as much of the report as you can.

IF YOU NEED HELP

You can get help from other people, such as a friend or family member. Please **do not** ask your health care provider to complete this report. If you cannot complete the report, a Social Security Representative will assist you. If you have an appointment, please have the completed report ready when we contact you.

Note: If you are assisting someone else with this report, please answer the questions as if that person were completing the report.

HOW TO COMPLETE THIS REPORT

- Print or write clearly.
- Include a ZIP or postal code with each address.
- Provide complete phone numbers, including area code. If a phone number is outside the United States, provide International Direct Dialing (IDD) code and country code.
- If you cannot remember the names and addresses of your health care providers, you may be able to get that information from the telephone book, Internet, medical bills, prescriptions, or prescription medicine containers.
- **ANSWER EVERY QUESTION**, unless the report indicates otherwise. If you do not know an answer, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- Be sure to explain an answer if the question asks for an explanation or if you want to give additional information.
- If you need more space to answer any question, please use **Section 11 - Remarks**, on the last page to finish your answer. Write the number of the question you are answering.

YOUR MEDICAL RECORDS

If you have any of your medical records covering the last 12 months, send or bring them to our office with this completed report. Please tell us if you want to keep your records so we can return them to you. If you have a scheduled appointment for an interview, bring your medical records, your prescription medicine containers (if available), and the completed report with you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will request your records. The information that you give us on this report tells us where to request your medical and other records.

The Privacy Act

Sections 205(a), 223(d), and 1631(e) (1) of the Social Security Act, as amended, authorize us to collect this information. The information you provide will be used to make a decision on the named claimant's claim. While giving us the information on this report is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. We generally use the information you supply for the purpose of making decisions regarding claims. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information about Social Security records (e.g., to the Government Accountability Office and the Department of Veterans Affairs); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and, (4) to facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.socialsecurity.gov or at any local Social Security office.

The Paperwork Reduction Act

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 60 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed report.**

SEND OR BRING THE COMPLETED REPORT TO YOUR LOCAL SOCIAL SECURITY OFFICE, THE NEAREST U.S EMBASSY OR CONSULATE OFFICE. Office addresses are listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778) for the address.

AFTER COMPLETING THIS FORM, REMOVE THIS SHEET AND KEEP IT FOR YOUR RECORDS.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0072

CONTINUING DISABILITY REVIEW REPORT

For SSA Use Only - Do not write in this box. **Date of your last medical disability decision:** _____

Claim Number: _____ Number Holder _____

Type(s) of Case(s): (Check all that apply.)

TITLE II	☐ DIB	☐ DWB	☐ CDB	☐ FZ	☐ ESRD	☐ HIB
TITLE XVI	☐ DI	☐ DS	☐ DC	☐ BI	☐ BS	☐ BC

If you are filling out this report for the disabled person, please provide information about him or her. When a question refers to "you", "your", or the "disabled person", it refers to the person receiving disability benefits.

SECTION 1- INFORMATION ABOUT THE DISABLED PERSON

1.A. NAME (first, middle initial, last)

1.B. SOCIAL SECURITY NUMBER
- -

1.C. MAILING ADDRESS (Street or PO Box) Include apartment number if applicable

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

1.D. DAYTIME PHONE NUMBER including area code, and the IDD and country codes if you live outside the USA or Canada.

Phone number _____

☐ Check this box if you have a phone or a number where we can leave a message

1.E. Alternate Phone Number, including area code where we may reach you, if any

Alternate phone number _____

1.F. Can you speak and understand English? ☐ YES ☐ NO

If no, what language do you prefer? _____
If you cannot speak and understand English, we will provide an interpreter, free of charge.

1.G. Have you used any other names on your medical or educational records in the last 12 months? Examples are maiden name, other married names, or nickname. ☐ YES ☐ NO

If yes, please list them here _____

SECTION 2 - CONTACTS

Give the name of a friend or relative (other than your doctors) we can contact who knows about your medical conditions, and can help you with your case.

2.A. NAME (first, middle initial, last)

2.B. Relationship to Disabled Person

2.C. MAILING ADDRESS (Street or PO Box) Include apartment number if applicable

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

2.D. DAYTIME PHONE NUMBER (as described in 1.D. above)

_____

2.E. Can this person speak and understand English? ☐ YES ☐ NO

If no, what language is preferred? _____

SECTION 2 - CONTACTS (continued)

2.F. Who is completing this report?

- ☐ The disabled person listed in 1.A (Go to **Section 3 - Medical Conditions**)
- ☐ The person listed in 2.A (Go to **Section 3 - Medical Conditions**)
- ☐ Someone else (Complete the rest of Section 2 below)

2.G. NAME (first, middle initial, last)	**2.H.** Relationship to Disabled Person

2.I. DAYTIME PHONE NUMBER (as described in 1.D. above)

_____

2.J. MAILING ADDRESS (Street or PO Box) Include apartment number if applicable

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

SECTION 3 - MEDICAL CONDITION(S)

3.A. If you are an adult (age 18 or older), list the physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work. **If you are completing this report for a child (under age 18),** list the physical and/or mental condition(s) (including emotional and learning problems) that limit the child's ability to do the same things as other children the same age. **List each physical and/or mental condition separately.**

1.

2.

3.

4.

If you need more space go to Section 11 - Remarks on last page

3.B. What is your height without shoes?

_____ feet _____ inches OR _____ centimeters (if outside USA)

3.C. What is your weight without shoes?

_____ pounds OR _____ kilograms (if outside USA)

SECTION 4 - WORK
Complete only if you are age 14 years old or older

4. Since the date of your last medical disability decision have you worked? (see date at top of Page 1)

☐ YES (If yes, we may contact you for additional information) ☐ NO

SECTION 5 - MEDICAL TREATMENT

Within the last 12 months, have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or **do you have a future appointment scheduled:**

5.A. For any **physical** conditions?

☐ YES ☐ NO

5.B. For any **mental** condition(s) **(including emotional or learning problems)**

☐ YES ☐ NO

If you answered "No" to both 5.A. and 5.B., go to Section 6 - Other Medical Information on page 8

SECTION 5 - MEDICAL TREATMENT (continued)

5.C. Tell us who may have medical records covering **the last 12 months** about any of your physical or mental condition(s) **(including emotional or learning problems)**. This includes doctors' offices, hospitals (including emergency room visits), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

Name of facility or office	Name of health care professional that treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROFESSIONAL ABOVE.

PHONE ( ) -	PATIENT ID# (if known)

MAILING ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

Dates of Treatment (within the last 12 months)

1. Office, Clinic or Outpatient visits

First Visit _____

Last Visit _____

Next Scheduled Appointment (if any) _____

2. Emergency Room Visits
List the most recent date first

A. _____

B. _____

C. _____

3. Overnight Hospitals Stays

A. Date in _____ Date out _____

B. Date in _____ Date out _____

C. Date in _____ Date out _____

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in the box.)

Check the boxes below for any tests this provider performed or sent you to **within the last 12 months,** or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use **Section 11** - **Remarks** on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

KIND OF TEST	DATES OF TESTs	KIND OF TEST	DATES OF TESTs
☐ 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 Scan (list body part) _____	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) _____	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 6 on page 8.

SECTION 5 - MEDICAL TREATMENT (continued)

5.D. Tell us who may have medical records covering **the last 12 months** about any of your physical or mental condition(s) **(including emotional or learning problems)**. This includes doctors' offices, hospitals (including emergency room visits), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

Name of facility or office	Name of health care professional that treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROFESSIONAL ABOVE.

PHONE ( ) -	PATIENT ID# (if known)

MAILING ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

Dates of Treatment (within the last 12 months)

1. Office, Clinic or Outpatient visits

First Visit _____

Last Visit _____

Next Scheduled Appointment (if any) _____

2. Emergency Room Visits

List the most recent date first

A. _____

B. _____

C. _____

3. Overnight Hospitals Stays

A. Date in _____ Date out _____

B. Date in _____ Date out _____

C. Date in _____ Date out _____

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in the box.)

Check the boxes below for any tests this provider performed or sent you to **within the last 12 months,** or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use **Section 11 - Remarks** on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

KIND OF TEST	DATES OF TESTs	KIND OF TEST	DATES OF TESTs
☐ 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 Scan (list body part) _____	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) _____	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 6 on page 8.

SECTION 5 - MEDICAL TREATMENT (continued)

5.E. Tell us who may have medical records covering **the last 12 months** about any of your physical or mental condition(s) **(including emotional or learning problems)**. This includes doctors' offices, hospitals (including emergency room visits), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

Name of facility or office	Name of health care professional that treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROFESSIONAL ABOVE.

PHONE ( ) -	PATIENT ID# (if known)

MAILING ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

Dates of Treatment (within the last 12 months)

1. Office, Clinic or Outpatient visits

First Visit

_____

Last Visit

_____

Next Scheduled Appointment (if any)

_____

2. Emergency Room Visits

List the most recent date first

A. _____

B. _____

C. _____

3. Overnight Hospitals Stays

A. Date in _____ Date out _____

B. Date in _____ Date out _____

C. Date in _____ Date out _____

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in the box.)

Check the boxes below for any tests this provider performed or sent you to **within the last 12 months,** or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use **Section 11 - Remarks** on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

KIND OF TEST	DATES OF TESTs	KIND OF TEST	DATES OF TESTs
☐ 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 Scan (list body part) _____	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) _____	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 6 on page 8.

SECTION 5 - MEDICAL TREATMENT (continued)

5.F. Tell us who may have medical records covering **the last 12 months** about any of your physical or mental condition(s) **(including emotional or learning problems)**. This includes doctors' offices, hospitals (including emergency room visits), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

Name of facility or office	Name of health care professional that treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROFESSIONAL ABOVE.

PHONE ( ) -	PATIENT ID# (if known)

MAILING ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

Dates of Treatment (within the last 12 months)

1. Office, Clinic or Outpatient visits	**2. Emergency Room Visits**	**3. Overnight Hospitals Stays**
First Visit _____	List the most recent date first	
Last Visit _____	A. _____	A. Date in _____ Date out _____
Next Scheduled Appointment (if any) _____	B. _____	B. Date in _____ Date out _____
	C. _____	C. Date in _____ Date out _____

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in the box.)

Check the boxes below for any tests this provider performed or sent you to **within the last 12 months,** or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use **Section 11 - Remarks** on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

KIND OF TEST	DATES OF TESTs	KIND OF TEST	DATES OF TESTs
☐ 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 Scan (list body part) _____	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) _____	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 6 on page 8.

SECTION 5 - MEDICAL TREATMENT (continued)

5.G. Tell us who may have medical records covering **the last 12 months** about any of your physical or mental condition(s) **(including emotional or learning problems)**. This includes doctors' offices, hospitals (including emergency room visits), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

Name of facility or office	Name of health care professional that treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROFESSIONAL ABOVE.

PHONE ( ) -	PATIENT ID# (if known)

MAILING ADDRESS

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

Dates of Treatment (within the last 12 months)

1. Office, Clinic or Outpatient visits	**2. Emergency Room Visits**	**3. Overnight Hospitals Stays**
First Visit _____	List the most recent date first	
Last Visit _____	A. _____	A. Date in _____ Date out _____
Next Scheduled Appointment (if any) _____	B. _____	B. Date in _____ Date out _____
	C. _____	C. Date in _____ Date out _____

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in the box.)

Check the boxes below for any tests this provider performed or sent you to **within the last 12 months,** or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use **Section 11 - Remarks** on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

KIND OF TEST	DATES OF TESTs	KIND OF TEST	DATES OF TESTs
☐ 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 Scan (list body part) _____	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) _____	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 6 on page 8.

If you are under age 18, Skip to Section 11 - Remarks on the last page.

SECTION 6 - OTHER MEDICAL INFORMATION
Complete only if you are age 18 years old or older

6. Does anyone else have medical information about your physical or mental condition(s) (including emotional and learning problems) **covering the last 12 months,** or are you scheduled to see anyone else? (This may include places such as workers' compensation, vocational rehabilitation, insurance companies who have paid you disability benefits, prisons, atttorneys, social service agencies and welfare.)

☐ YES (Complete the following information.) ☐ NO (Go to SECTION 7.)

NAME OF ORGANIZATION	PHONE NUMBER ( ) -
MAILING ADDRESS	

CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

NAME OF CONTACT PERSON	CLAIM NUMBER (if any)

Date First Contact (in last 12 months)	Date Last Contact (in last 12 months)	Date Next Contact (if any)

Reasons for Contacts

If you need to list other people or organizations use Section 11 - Remarks on the last page and give the same detailed information as above for each one you list.

SECTION 7 - MEDICINES

7. Are you now taking, or have you taken **in the last 12 months** , any prescription or non-prescription medicines?

☐ YES (Complete the following information. Look at your medicine containers, if

☐ NO (Go to SECTION 8.)

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE

If you need to list other medicines use Section 11 - Remarks on the last page

SECTION 8 - EDUCATION AND TRAINING
Complete only if you are age 18 years old or older

8.A. Have you received any education since your last disability decision? (See date at top of Page 1.)

☐ YES (Complete the information below.) ☐ NO, go to question **8.B** below

If Yes, what year did you last attend any school? _____

Please describe the education you received.

8.B. Have you received any type of specialized job, trade, or vocational training since your last disability decision? (See date at top of Page 1.)

☐ YES (Complete the information below.) ☐ NO

NAME OF TRAINING FACILITY			PHONE ( ) -
MAILING ADDRESS			
CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)
TYPE OF PROGRAM		Date Completed (or scheduled to be completed)	

If you need to list other education information or training facilities use Section 11 - Remarks on the last page and give the same detailed information as above

SECTION 9 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES
Complete only if you are age 18 years old or older

9.A. Since the date of your last medical disability decision (see date on top of Page 1), have you participated, or are you participating, in:

- an individualized work plan with an employment network under the Ticket to Work Program;
- an individualized plan for employment with a vocational rehabilitation agency or any other organization;
- a Plan to Achieve Self-Support (PASS);
- an Individualized Education Program (IEP) through a school (if a student age 18-21); or
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ YES (Complete the information below.) ☐ NO (Go to Section 10)

NAME OF ORGANIZATION OR SCHOOL			
NAME OF COUNSELOR, INSTRUCTOR, OR JOB COACH			PHONE NUMBER ( ) -
MAILING ADDRESS			
CITY	STATE/Province	ZIP/Postal Code	COUNTRY (if not USA)

9.B. When did you start participating in the plan or program? _____

SECTION 9 - VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT SERVICES (continued)
Complete if you are age 18 years old or older

9.C. Are you still participating in the plan or program?

☐ YES, I am scheduled to complete the plan or program on: _____ (date to be completed)

☐ NO, I completed the plan on: _____ (date completed)

☐ NO, I stopped participating in the plan before completing it because:

9.D. What types of services, tests, or evaluations were provided (for example: intelligence or psychological testing, vision or hearing test, physical exam, work evaluations, or classes?)

If you need to list another plan or program use Section 11 - Remarks on the last page and give the same detailed information as above

SECTION 10 - DAILY ACTIVITIES
Complete only if you are age 18 years old or older

10.A. Describe what you do in a typical day (for example: I get up around 7 A.M., take a shower, eat breakfast, etc.).

If you need more space, go to Section 11 - Remarks on the last page

10.B. Do you use an assistive device (for example: eye glasses, hearing aids, braces, canes, crutch(es), walker, wheelchair, service animal)?

☐ Always ☐ Sometimes ☐ Never

If ALWAYS OR SOMETIMES, please describe what kind, when, and how you use it.

If you need more space, use SECTION 11 - Remarks on the last page

10.C. Do you have hobbies or interests?

☐ YES ☐ NO

If YES, please decribe what they are and how much time you spend doing them.

If you need more space, use Section 11 - Remarks on the last page

SECTION 10 - DAILY ACTIVITIES (continued)
Complete only if you are age 18 years old or older

10.D. Do you ever have difficulty doing any of the following? (Please explain any "Yes" answers.)

Dressing	☐ Yes	☐ No
Bathing	☐ Yes	☐ No
Caring for hair	☐ Yes	☐ No
Taking medicines	☐ Yes	☐ No
Preparing meals	☐ Yes	☐ No
Feeding self	☐ Yes	☐ No
Doing chores (inside/outside house)	☐ Yes	☐ No
Driving or using public transportation	☐ Yes	☐ No
Shopping	☐ Yes	☐ No
Managing money	☐ Yes	☐ No
Walking	☐ Yes	☐ No
Standing	☐ Yes	☐ No
Lifting objects	☐ Yes	☐ No
Using arms	☐ Yes	☐ No
Using hands or fingers	☐ Yes	☐ No
Sitting	☐ Yes	☐ No
Seeing, hearing, or speaking	☐ Yes	☐ No
Concentrating	☐ Yes	☐ No
Remembering	☐ Yes	☐ No
Understanding or following directions	☐ Yes	☐ No
Completing tasks	☐ Yes	☐ No
Getting along with people	☐ Yes	☐ No

SECTION 11 - REMARKS

Please write any additional information you did not give in earlier parts of this report. If you did not have enough space in the sections of this report to write the requested information, please use this space to tell us the additional information requested in those sections. Be sure to show the section to which you are referring.

Date Report Completed (month, day, year)