





**STEP 3: Patient Information - must be completed by the member's attending physician who is a licensed and practicing MD or DO.**

Treated Member From: [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ] To: [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ]

Frequency of Office Visits for Disabling Condition(s):  Monthly  Qtr.  Semi-ann.  Ann.  Other

Date of Last Office Visit for the Disabling Condition(s): [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ]

**STEP 4: Physician Determination - must be completed by the member's attending physician who is a licensed and practicing MD or DO.**

For a member to be permanently disabled from their last public employment position, the disabling condition must be expected to last for at least 12 months and prevent the member from performing the duties of their last public employment position. Disability coverage does not extend to illness or injuries resulting from elective cosmetic surgery other than reconstructive surgery. Please include any test results that enabled you to make your diagnosis(es).

**You must complete either the YES section or the NO section below in its entirety for the form to be considered valid. If one of these sections is not completed this form will be invalid.**

Do you consider this member to be permanently disabled from their last public employment position as described above?  Yes  No

**If YES, complete below:**

What is the member's Primary Disabling Condition?

Corresponding ICD Code:

[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Date on which illness or injury occurred: [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ]

Date on which illness or injury became permanently disabling: [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ]

Has the member's condition progressed since the illness or injury occurred?  Yes  No

If NO, complete below:

Date on which illness or injury occurred: [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ]

What is the expected date the member could return to their public employment position? [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ]

Could the member return to work with restrictions and/or limitations?  Yes  No

If yes, please describe:

[Empty text box for description]

Part 2: This section is required to be completed or the form will be invalid.

**PROGNOSIS FOR RECOVERY FROM DISABLING CONDITION(S)**

[Large empty box for prognosis text]

Physician's Name

[Empty text box for physician name]

Physician's Signature \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Do not print or type name

Physician's Medical Title

MD DO

[Empty text boxes for medical title and MD/DO selection]

**STEP 5: Physician Findings - must be completed by the member's attending physician who is a licensed and practicing MD or DO. PLEASE ATTACH ALL MEDICAL AND/OR PSYCHOLOGICAL RECORDS WITHIN THE LAST 12 MONTHS, INCLUDING OFFICE NOTES, CLINIC AND ER VISITS, LABS, ALL TEST RESULTS AND DISCHARGE SUMMARIES. PLEASE NOTE – UNABLE TO ACCEPT DIGITAL MEDIA, ONLY INCLUDE REPORT FINDINGS.**

Please complete each applicable section based on the disabling condition. The medical data provided by you in the report (clinical findings, diagnosis, test results) will be used to adjudicate the disability determination process.

**PART I – Medical Information**

(For disabling psychological conditions only, proceed to Part II.)

(If no disabling psychological conditions, proceed to Part III upon completion.)

**CURRENT MEDICATIONS**

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**MEDICAL HISTORY**

*[Include hospitalizations within the past five years. (List facilities, dates and reasons for admission(s))]*

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**PHYSICAL EXAMINATION**

Complete the following section **only** providing information that is related to the disabling condition(s).

Temperature:	Blood Pressure:	Height:	Weight:	Pulse:	Respiratory Rate:

General appearance:

**VISION**

*[For example: Ophthalmological changes, cataract(s); glaucoma; macular problems; diabetic retinopathy; Certificate of Blindness; best corrected visual acuity; visual field testing]*

<b>VISION</b> <i>[For example: Ophthalmological changes, cataract(s); glaucoma; macular problems; diabetic retinopathy; Certificate of Blindness; best corrected visual acuity; visual field testing]</i>

**HEARING**

*[For example: Whispered/spoken word; cochlear implant; Other amplification devices; Use of American Sign Language (ASL); Audiological Evaluation (including audiogram); vestibular testing; electronystagmography (ENG)]*

<b>HEARING</b> <i>[For example: Whispered/spoken word; cochlear implant; Other amplification devices; Use of American Sign Language (ASL); Audiological Evaluation (including audiogram); vestibular testing; electronystagmography (ENG)]</i>

**RESPIRATORY SYSTEM**

*[For example: Pulmonary function; lung function (wheezes, rhonchi, or rales); cyanosis/dyspnea; chest x-ray report; pulmonary function test; arterial/gas studies; in the case of pulmonary tuberculosis, provide sputum culture results]*

**CARDIOVASCULAR SYSTEM**

*[For example: Blood pressure readings; indication of chest pain; edema, pigmentation, cyanosis or ulceration; end-organ damage as result of hypertension; indicate New York Heart Classification; chest x-ray report; electrocardiogram (EKG) report; echocardiogram (ECHO) report; Exercise Tolerance Test]*

**DIGESTIVE SYSTEM**

*[For example: Weight loss; liver studies; x-ray report; endoscopy; colonoscopy; pathology]*

**GENITOURINARY SYSTEM**

*[For example: Report of dialysis treatment; history of transplant; BUN; Creatine Clearance]*

**HEMATOLOGICAL SYSTEM**

*[For example: Indication of the following: anemias, bone marrow disorders, etc.; blood transfusions; stem cell transplant; complete blood count]*

**SKIN**

*[For example: Extent of lesions and part of body system impacted; if burn(s), total body surface area involvement; other pertinent findings if critical areas of the body are involved (such as palms of hands and soles of feet); biopsy; pathology]*

**ENDOCRINE SYSTEM**

*[For example: Diabetes; evidence of neuropathy; acidosis; amputations; ophthalmological changes; lab studies]*

**MUSCULOSKELETAL SYSTEM**

*[For example: Limitation of motion and the degree; comment on history of pain, swelling, and stiffness; MRI report; x-ray report; ESR/RF studies]*

**NEUROLOGICAL SYSTEM**

*[For example: Reflexes; motor strength; sensation (light touch, pin prick, vibration and position); cranial nerves; cerebellar function (include observed ambulation); mental status (i.e., oriented X3, confused, etc.); electromyography (EMG); nerve conduction study (NCS); electroencephalogram (EEG)]*

**MALIGNANT NEOPLASMS**

*[For example: Type, extent and site of the primary recurrent or metastatic lesion; treatment plan and prognosis; operative procedures including biopsy or needle aspiration; operative note or pathology report]*

**IMMUNE SYSTEM**

*[For example: Indication of the following: autoimmune disorder(s) (such as Lupus), immunodeficiency disorder(s) (primary or acquired), HIV infection, etc.; any constitutional symptoms such as fatigue, fever, malaise, etc.; blood studies; angiography; x-ray; CAT scan report; MRI report]*

**OTHER**

*[Please indicate any other pertinent physical examination findings and/or laboratory/diagnostic studies not listed above.]*

**Part II – Psychological Information**

(If no disabling psychological conditions, proceed to Part III.)

**CURRENT MEDICATIONS**

**PSYCHIATRIC HISTORY**

*[Include hospitalizations within the past five years. (List facilities, dates and reasons for admission(s).)]*

**MENTAL STATUS ASSESSMENT**

Complete the following section **only** providing information that is related to the disabling condition(s).  
(If no psychological conditions, proceed to Part III.)

**Current clinical signs and symptoms that support the diagnosis(es)** (sleep, interest, guilt, energy, concentration, appetite, psychomotor, suicidal ideation, etc.)

**APPEARANCE/ATTITUDE/BEHAVIOR**

*[For example: Personal hygiene and grooming]*

**ORIENTATION**

*[For example: Person, date, place]*

**MOOD AND AFFECT**

*[For example: Labile, blunt, flat]*

**SPEECH**

*[For example: Pressured, paucity of speech, etc.]*

**THOUGHT PROCESS**

*[For example: Dissociation, blocking, flight of ideas, etc.]*

**THOUGHT CONTENT**

*[For example: Phobias, obsessions, delusions, ideas of reference, etc.]*

**PERCEPTIONS**

*[For example: Hallucinations – auditory or visual]*

**COGNITION**

*[For example: Impairment of memory, judgment/ability to perform calculations, level of intellectual function, ability to concentrate and/or learn]*

**SOCIAL**

*[For example: Ability to interact with others or those in a position of authority]*

**OTHER**

*[Please indicate any other pertinent clinical findings not listed above and/or results of neuropsychiatric testing.]*

### Part III – Treatment and Prognosis

#### HISTORICAL TREATMENT

*[For example: Successful and failed treatments]*

#### CURRENT TREATMENT

Has member shown medical improvement with Current Treatment?  Yes  No

**If yes, indicate level of improvement:**  Fair  Moderate  Good  Excellent

