Physician's Report on Disability

Notice To Physician

This form must be completed by a medical doctor. The following information is needed for use in connection with the patient's application for disability retirement allowance under the California Public Employees' Retirement Law. Please provide your full reply, in order to completely describe the nature and severity of impairment. Also, include copies of your medical reports.

_____/_____/_____/_____

Member SSN | Member Name | Date of Birth | Position/Occupational Title

For Kaiser Patients, Medical Record Number: _____

Part 1 History

Date of First Visit: _____ Date of Last Visit: _____

Date Present Illness/Injury Occurred: _____ Date Applicant Unable to Work: _____

Origin of Injury: ☐ Work Related ☐ Non Work Related

Describe How Injury Occurred: _____

Part 2 Present Condition

Height: _____ Weight: _____ Blood pressure: _____

Subjective Symptoms: _____

Part 3 Diagnosis / Objective Findings

Diagnosis: _____

Objective Findings:

Cardiac: _____

Orthopedic: _____

Psychological: _____

Pulmonary: _____

Visual: _____

Neurological: _____

Other: _____

☐ Atrophy ☐ Hemiplegia ☐ Tremors ☐ Paralysis ☐ Gait

☐ Impaired Speech ☐ Mental Disturbances

Provide dates and findings of any X-rays, EKGs, laboratory or diagnostic testing performed. Use additional sheets if necessary.

_____

_____

_____

PERS01M0051DMC (Rev. 11/04)

Part 4 Medical Qualifications and Statement of Incapacity (ALL QUESTIONS MUST BE ANSWERED.)

To qualify for a disability retirement, the CalPERS member must be substantially incapacitated for the performance of the usual duties of his/her position with the current employer. In addition, the member must also be substantially incapacitated from performing the usual duties of the position for other California public agencies in CalPERS. (California public agencies in CalPERS includes state, school and public employers.) This "substantial incapacity" must be due to a medical condition of permanent or extended and uncertain duration. Disability is not necessarily an inability to perform fully every function of a given position. Rather, the courts have concluded that the test is whether the member has a substantial inability to perform the usual and customary duties of the position. **Prophylactic restrictions are not a basis for a disability retirement.** You must review the attached duty statement and physical requirements of the member's position prior to answering the following questions:

1. Is the member presently, substantially incapacitated from performance of the usual duties of the position for their current employer? ☐ Yes ☐ No

   a. If yes, describe specific work activities that the member is unable to perform due to incapacity. _____

   _____

   _____

2. Is the member presently, substantially incapacitated from the performance of the usual duties of the position for other California public agencies in CalPERS? ☐ Yes ☐ No (California public agencies in CalPERS includes state, school and public employers.)

   Please explain. _____

   _____

3. Will Incapacity Be Permanent? ☐ Yes ☐ No

   a. If not, Probable Duration: ☐ < 6 months ☐ 6 months – 1 year ☐ 1 – 2 years ☐ Other _____

4. What information did you review to make your medical opinion? *Check all that apply.*

   ☐ Job Description/Duty Statement ☐ Physical Requirements ☐ Information provided by member

   ☐ Other _____

   Attach all information reviewed, to this report.

Part 5 Mental Status

Is member mentally able to handle financial affairs & enter into legally binding contracts? ☐ Yes ☐ No
If no, date of onset: _____

Is member competent to endorse checks with the realization of nature & consequence of the act? ☐ Yes ☐ No
If no, date of onset: _____

Part 6 Signature

Mail completed report directly to CalPERS. **Do not give to applicant.**

CalPERS has my permission to release a photocopy of report to applicant, upon written request. ☐ Yes ☐ No

_____ (____) _____ (____) _____
Printed Name of Physician Telephone Number Fax Number

_____
Address City State Zip

_____
Signature of Physician/Title **Date**