Physician's Report on Disability

888 CalPERS (or 888-225-7377) • TTY: (877) 249-7442 • Fax: (916) 795-1280

This form must be completed by a physician/medical specialist who specializes in your disabling condition. The following information is needed in connection with the patient's application for disability retirement benefits under the California Public Employees' Retirement Law. Type or print clearly.

Section 1 — Member Information

Please fill out completely and fully describe the nature and severity of impairment. Also, include copies of the patient's medical and referenced diagnostic test reports.

SHELDON K. SCARBER — Name of Member (First Name, Middle Initial, Last Name)
[redacted] — Social Security Number or CalPERS ID
CHP / ASSISTANT CHIEF — Position/Occupational Title
[redacted] — Birth Date (mm/dd/yyyy)
For Kaiser Patients, Medical Record Number

Section 2 — Member History

Please provide history of patient's illness/injury.

Patient and Member are the same person.

6/29/06 — Date of First Visit (mm/dd/yyyy)
2/27/2013 — Date of Last Examination (mm/dd/yyyy)
1997 (CUMULATIVE) — Date Present Illness/Injury Occurred (mm/dd/yyyy)
12/20/12 — Date Member Unable to Perform Job Duties (mm/dd/yyyy)

Origin of Injury: ☒ Work Related ☐ Non-Work Related

Describe How Injury Occurred: Cumulative events from 1997 → present

Section 3 — Examination Findings

Please provide history of patient's illness/injury.

Chief Complaints: Chest pain, fatigue, neuro changes, headaches, vagal attacks, Panic Attacks,
Subjective Symptoms: as above, loss of consciousness,
Height: 73" — Weight: 186# — Blood Pressure: 152/98
pron and subjective sudden onset of dizziness, Kaiser visit and syncope Heart palpitations

Section 4 — Diagnosis

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

If there is not enough space to enter all your diagnosis, attach a separate sheet. Be sure to use a label, or clearly write your Social Security number on each attachment.

Diagnosis 1: Chest pain, Palpitations, PTSD
Objective Examination Findings 1: ↑BP, Abn EKG
Diagnostic Test – Dates and Findings: Angiogram, Echo, EKG – Dr D. Sandhu
Restrictions/Limitations, if so specify: 1/26/13, 2/7/12, 7/12

Diagnosis 2:
Objective Examination Findings 2: instability, Weakness
Diagnostic Test – Dates and Findings: MRI Head 4/1/13 White matter changes? demyelinating disease
Restrictions/Limitations, if so specify: Optical Consult 4/21/13 c/ ? demyelinating disease

Comments

RESPONDENT'S EXHIBIT I
PENGAD 800-631-6989

Put your name and Social Security number or CalPERS ID at the top of every page

SHELDON K. SCARBER
Your Name

[redacted]
Social Security Number or CalPERS ID

Section 5 Member Incapacity

Review the attached duty statement and physical requirements of the member's position prior to answering these questions.

To qualify for a disability retirement, the CalPERS member must be substantially incapacitated from the performance of the usual duties of his/her position with the current employer. 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.**

1. Is the member currently, substantially incapacitated from performance of the usual duties of the position for their current employer? ☒ Yes ☐ No
   If yes, you must describe specific job duties/work activities that the member is unable to perform due to incapacity. Refer to member's job duty statement and *Physical Requirements of Position/Occupational Title* form.
   Assisting, advising in all matters, guiding, counseling, training, communication with Division Commander, any & all duties as described
2. Will the incapacity be permanent? ☒ Yes ☐ No
   If not, probable duration ☐ < 6 months ☐ 6 months – 1 year ☐ 1 – 2 years ☐ Other
   If other, please describe _____.
3. Was the job duty statement/job description reviewed to make your medical opinion? ☒ Yes ☐ No
4. Was the *Physical Requirements of Position/Occupational Title* form reviewed to make your medical opinion? ☒ Yes ☐ No
5. Was information reviewed that the member provided? ☐ Yes ☒ No
   If so, please attach the information provided by the member.

Section 6 Member Mental Status

Is the member mentally able to handle financial affairs and enter into legally binding contracts?
☒ Yes ☐ No _____ Date of Onset (mm/dd/yyyy)

Is the member competent to endorse checks with the realization of nature and consequence of the act?
☒ Yes ☐ No _____ Date of Onset (mm/dd/yyyy)

Section 7 Physician's Signature

Mail completed report directly to CalPERS. Do not give to member.

All questions on this form must be answered or application will be incomplete, which will delay processing.

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

Print Physician Name	Phone Number	Fax Number
Robert Graham	559 436-5265	559 436-4958

Address: 6081 N 1st #104

City: Fresno | State: CA | ZIP: 93710

Signature of Physician/Title: [signature] MD | Medical Specialty: PCP | Date (mm/dd/yyyy): 02/27/2013

Mail to: **CalPERS Benefit Services Division** • P.O. Box 2796, Sacramento, California 95812-2796

CID# [redacted]

Physical Requirements of Position/Occupational Title

888 CalPERS (or 888-225-7377) • TTY: (877) 249-7442 • Fax: (916) 795-1280

Section 1 — Member Information

This form must be completed by the member and their employer to supplement the physical requirements listed on the member's job duty statement/job description.

SHELDON K. SCARBER — Name of Member (First Name, Middle Initial, Last Name)
[redacted] — Social Security Number or CalPERS ID

CHP / ASST. CHIEF — Position/Occupational Title
CHP — Name of Employer

5179 N. GATES AVE — Worksite Street Address

FRESNO — City
CA — State
93720 — ZIP

Section 2 — Physical Requirements Information

Indicate with a check mark (✓) the frequency required for each activity listed at the right.

Activity	Never	Occasionally Up to 3 hours	Frequently 3–6 hours	Constantly Over 6 hours	Distance/ Height
Sitting		X			
Standing		X			
Running		X			
Walking		X			
Crawling		X			up to 50'
Kneeling		X			up to 30 sec.
Climbing		X			approx 40'
Squatting		X			up to 30 sec.
Bending (neck)			X		
Bending (waist)		X			up to 30 sec.
Twisting (neck)			X		
Twisting (waist)		X			
Reaching (above shoulder)		X			
Reaching (below shoulder)		X			
Pushing & Pulling		X			up to 40' and 50 lbs
Fine Manipulation		X			
Power Grasping		X			up to 20 sec.
Simple Grasping		X			up to 20 sec.
Repetitive use of hand(s)				X	continuous use?
Keyboard Use				X	
Mouse Use				X	
Lifting/Carrying					
0 – 10 lbs.		X			
11 – 25 lbs.		X			
26 – 50 lbs.		X			50 yes
51 – 75 lbs.		X			
76 – 100 lbs.		X			up to 100 lb victim 50 ft.
100 + lbs.		X			

Continued on page 2.

CID# [redacted]

Put your name and Social Security number or CalPERS ID at the top of every page.

Your Name: SHELDON K. SCARBSL

Social [redacted]

Section 2 (continued)

Physical Requirements, continued

Indicate with a check mark (✓) the frequency required for each activity listed at the right.

If there is not enough space to enter all your additional requirements or comments, attach a separate sheet. Be sure to use a label, or clearly write your name and Social Security number on each attachment.

Activity	Never	Occasionally Up to 3 hours	Frequently 3–6 hours	Constantly Over 6 hours	Distance/ Height
Walking on uneven ground		X			
Driving				X	
Working with heavy equipment	X				
Exposure to excessive noise		X			
Exposure to extreme temperature, humidity, wetness		X			
Exposure to dust, gas, fumes, or chemicals		X			
Working at heights	X				
Operation of foot controls or repetitive movement			X		
Use of special visual or auditory protective equipment	X				
Working with bio-hazards (e.g., blood-borne pathogens, sewage, hospital waste, etc.)	X		X		

Section 3

Signature of Employer and Member

This form must be completed and signed by you and your employer and sent to a medical specialist along with other documentation.

If you are a Disability Retirement Election applicant, your employer must provide you a copy of this completed form. Your employer must send the signed original to CalPERS.

Also, you must attach your current job duty statement/job description and a copy of the ***Physical Requirements of Position/Occupational Title*** form to the ***Physician's Report on Disability*** form prior to sending them to a medical specialist. Complete document submittal requirements are described in ***A Guide to Completing Your CalPERS Disability Retirement Election Application.***

The medical specialist must be the treating physician specializing in your disabling condition.

If you are a Request to Work While Receiving Disability/Industrial Disability Benefits applicant or a Reinstatement from Disability/Industrial Disability Retirement applicant, you must attach the job duty statement/job description of the prospective job to a copy of the completed ***Physical Requirements of Position/ Occupational Title*** form prior to sending them to a medical specialist. You must submit the resulting medical report and other required documents to CalPERS. The ***Physician's Report on Disability*** form is not required.

Signature of Employer Representative: [signature] — Date (mm/dd/yyyy): 2/27/13

Title: CHIEF — Phone Number: (559) 277-7250

CalPERS Business Partner ID:

Signature of Member: [signature] — Phone Number: [redacted] — Date (mm/dd/yyyy): 2/22/13

Mail to: **CalPERS Benefit Services Division** • P.O. Box 2796, Sacramento, California 95812-2796