CalPERS

State of California
California Public Employees' Retirement System
www.calpers.ca.gov

Physician's Report on Disability (Local Safety)

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

Section 1: Employer Information

Employer must fill out this section.

Employer Name

Employer Address **City** **State** **Zip Code**

Employer Contact Person **Job Title**

Contact Person's Phone Number **Contact Person's Email**

Section 2: Member Information

Employer must fill out this section and send the form with the duty statement and physical requirements to the member's medical specialist for review and completion.

Member's Name (First Name, Middle Name, Last Name)

Social Security Number or CalPERS ID

Position/Occupation Title **Birth Date (mm/dd/yyyy)**

For Kaiser Patients, Medical Record Number

Section 3: Member History

Physician please provide history of patient's illness/injury. Patient and member are the same person.

Date of First Visit (mm/dd/yyyy) **Date of Last Examination (mm/dd/yyyy)**

Date Present Illness/Injury Occurred (mm/dd/yyyy) **Date Member Unable to Perform Job Duties (mm/dd/yyyy)**

Origin of injury: ☐ Work Related ☐ Non-Work Related

Describe How Injury Occurred

Member's name **Social Security Number or CalPERS ID**

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

Section 4: Examination Findings

Physician please provide history of patient's illness/injury.

Chief Complaints

Subjective Symptoms

Height **Weight** **Blood Pressure**

Section 5: 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 fill in your diagnosis, attach a separate sheet. Be sure to use a label, or clearly write the member's Social Security number on each attachment.

Diagnosis 1

Objective Examination Finding 1

Diagnostic Test – Dates and Findings

Restrictions/Limitations, if so, specify.

Diagnosis 2

Objective Examination Finding 2

Diagnostic Test – Dates and Findings

Restrictions/Limitations, if so, specify.

Diagnosis 3

Objective Examination Finding 3

Diagnostic Test – Dates and Findings

Restrictions/Limitations, if so, specify.

Comments

Member's name **Social Security Number or CalPERS ID**

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

Section 6: Member Incapacity

Review the attached duty statement and physical requirements of the member's position prior to answering these questions. Also, include with this form copies of the member's medical records and referenced diagnostic test reports.

To qualify for a disability retirement, the CalPERS member must be substantially incapacity 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 duration that is expected to last at least 12 consecutive months or will result in death. 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 of 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.

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2. Will the incapacity be permanent? ☐ **Yes** ☐ **No**
   If not, will the incapacity last longer than 12 months? ☐ **Yes** ☐ **No**

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 that the employer provided reviewed? ☐ **Yes** ☐ **No**
   If so, please attach the information provided by the employer.

6. Are you sending copies of the member's medical records and referenced diagnostic test reports along with this form to support your opinion? ☐ **Yes** ☐ **No**
   Failure to provide these documents will delay processing.

Section 7: Physician's Signature

Mail completed report directly to the employer's address listed in Section 1. **Do not give them to the 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**

Address **City** **State** **Zip**

Signature of Physician / Title **Medical Specialty** **Date (mm/dd/yyyy)**

Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested is collected pursuant to the Government Code (sections 20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

Social Security Numbers

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/ employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights

You have the right to review your membership files maintained by the System. For questions about this notice, our Privacy Policy, or your rights, please write to the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call us at 888 CalPERS (or 888-225-7377).