Physician's Statement for Occupational Disability

MEMBER INFORMATION

Please type or use only black ink and do not highlight. Any corrections must be initialed.

Member's Name (first, middle, last) _____ Social Security Number _____

Mailing Address _____ Daytime Phone Number _____

City _____ State _____ Zip _____ Member's Employing City _____

Do not complete this form if a copy of the City Statement is not attached.

DISABILITY INFORMATION

• *You will need to attach additional documentation to support your answers to the questions below (i.e. current history and physical, narrative report or comprehensive consultation or any other documentation which will assist TMRS in making a determination regarding occupational disability).*

1. Provide your diagnosis of physical or mental disability (attach second sheet if necessary):

   _____

   _____

2. Date of onset: _____ Date of first visit for condition leading to disability: _____

   Date of last examination: _____

3. Are you still attending the member? ☐ yes ☐ no ***(check one)***

4. List all other physicians who have attended the member during present disability:

Physician's Name	**Address**	**Dates Attended**

5. Describe the symptoms and physical findings pertinent to your diagnosis (attach copies of any CAT scans, MRI studies, or other pertinent reports):

   _____

   _____

6. From present indications, what seems to be the most probable course of this patient's illness?

   _____

   _____

7. Please review the **attached *City Statement for Occupational Disability* form** (TMRS-40/OA).

   Can the above named member perform all duties and activities of the job as described on the *City Statement for Occupational Disability* form TMRS-40/OA? ☐ yes ☐ no ***(check one)***

   If no, please list those activities described on the *City Statement for Occupational Disability* form (TMRS-40/OA) which, in your opinion, the member cannot perform due to the physical or mental disability described (attach second sheet if necessary):

Activity	**Frequency**	**Duration**

PHYSICIAN INFORMATION

Physician's Name *(printed or typed)* _____

Physician's Mailing Address _____

Physician's Signature _____ Date Signed (MM/DD/YYYY) _____

Please read the instructions provided with this form.

NOTES TO PHYSICIAN

- All medical information you submit is for interpretation by actively licensed physicians to determine the member's disability status according to the laws governing the Texas Municipal Retirement System. The System needs the answers to all of the questions. Copies of a current history and physical, hospital discharge summary, narrative report or comprehensive consultation, or other supporting documentation, will assist TMRS to make a determination and may expedite processing of your patient's application.

- The City Statement for Occupational Disability **MUST BE ATTACHED** in order to complete the Physician's Statement. If the City Statement is not provided, please contact TMRS or your patient.

TMRS WILL NOT ACCEPT

- Illegible forms. All forms should be typed. Handwritten forms will be accepted only if legible and if completed in black or blue ink
- Alterations without initials
- An incomplete form or any attempt to change its provisions