

Physician's Statement

Note to Physician:

The ultimate decision concerned with the gravity of a disability benefit is made by the Executive Director of the Minnesota State Retirement System based on the recommendation of the System's medical advisor. The weight given to the physician's statement on disability depends on support by specific and complete clinical findings and other evidence including laboratory and diagnostic tests. ***ALL MEDICAL REPORTS ARE REVIEWED BY THE SYSTEM'S MEDICAL ADVISOR.***

A narrative statement will be accepted in lieu of this form if all questions are answered in sufficient detail.

THE LAW DEFINES A DISABILITY FOR THE STATE PATROL PLAN AS:

- (a) A condition which renders a member physically or mentally unfit to perform the duties of the position as a direct result of an injury, sickness, or other disability incurred in or arising out of an act of duty; **or**
- (b) A condition which renders a member unfit to perform the duties of the position because of sickness or injury occurring while not engaged in covered employment.

THE LAW DEFINES A DISABILITY FOR THE CORRECTIONAL PLAN AS:

- (a) A condition which renders a covered correctional employee physically or mentally unfit to perform the duties of the position as a direct result of an injury, sickness, or other disability incurred in or arising out of an act or duty; **or**
- (b) A condition which renders a covered correctional employee unfit to perform the duties of the position because of sickness or injury occurring while not engaged in covered employment.

FORM MUST BE COMPLETED IN INK OR ON TYPEWRITER.

Birth date: _____ MSRS ID #: _____

Employee name: _____ Employee's department: _____

Address: _____
Street City State Zip

1. Date of examination: _____
Month Day Year

2. When did this illness or injury first occur? _____
Month Day Year

3. How long have you treated this patient? _____

4. Names of other treating physicians, if known: _____

5. Did illness or injury result from employment? Yes No

Give history of illness: _____

6. Diagnosis or diagnoses: _____

7. Clinical findings (give all pertinent signs and symptoms that support the relevant diagnosis): _____

8. Laboratory and diagnostic tests (includes dates and results relevant to diagnosis): _____

9. Is condition static? Yes No

What optimum improvement can be expected, if any? _____

10. In your opinion, is this employee disabled as defined on Page 1? Yes No

11. If answer to question 10 is yes, what date did the disability begin? _____
Month Day Year

12. In your opinion, is the disability work-related? Yes No

CERTIFICATE

I, the undersigned, a practicing physician, psychologist or chiropractor duly registered under the laws of the State in which I practice, do hereby certify that my answers to the foregoing questions are complete and true to the best of my knowledge, information and belief.

Dr. _____
Name (type or print)

Signature Medical Title

Date Phone Number

Street City State Zip Code