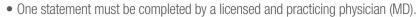
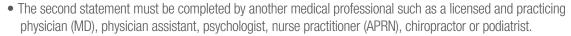


## Medical Statement Correctional Retirement Plan

## Two medical statements must be provided as evidence of an illness, injury or condition.







All medical information is reviewed by the MSRS medical advisors. Approval of a disability benefit is determined by the Executive Director of the Minnesota State Retirement System (MSRS) based on the recommendation of MSRS' medical advisors.

A narrative statement will be accepted in lieu of this form if all questions presented are addressed, opinions are clearly stated, and it is signed and dated by a **practicing physician**, **physician assistant**, **psychologist**, **nurse practitioner (APRN)**, **chiropractor**, **or podiatrist**.

Submit supporting clinical findings and other evidence including laboratory and diagnostic tests.

After approval of a disability benefit, the employee's disability status may need to be **recertified** by a medical professional **once a year for the first five years** and **once every three years thereafter** until they reach full retirement age.

## Definition of Correctional Retirement Plan Occupational Disability:

State law defines disability as a physical or psychological condition lasting at least one year that prevents a member from performing normal job duties. There are two types of disability:

- **Duty-related disability**. An injury must be incurred or a disease must arise while performing normal or less frequent duties that present inherent danger and are specific to a position covered by the plan.
- Regular disability. An injury may be incurred or a disease may arise from activity while not at work, or while at work and performing normal or less frequent duties that do not present inherent danger and are specific to a position covered by the plan.

1	Patient information

Last name	First name	MI
MSRS ID or SSN	Date of birth	
2. Medical information		
Primary disabling condition:     International Classification of Diseases (ICD) Code:		
2. Onset of disabling condition:/_/ Month Day Year		
3. Most recent examination for disabling condition:/	ay Year	
4. How long have you treated this patient? From/	Year To / / Month Day Year	
5. How long have you treated this patient for this disabling condi		/ / Month Dav Year

aboratory and diagnostic tests relevant to disabling condition:  escribe the current and past treatment plans, including medications:    See attachment for current/past treatment plans, including medications.    Date   Treatment Plan   Medications    Current reatment   Plan     Past reatment Plan     Past reatment Plan     Past reatment Plan     Past reatment Plan     Past reatment Plan     Past reatment Plan     Past reatment Plan     Past   Past     Past		lers or Clinic	Specialty	Dates of Medic First	al Appointment  Most Recent
aboratory and diagnostic tests relevant to disabling condition:  escribe the current and past treatment plans, including medications:    See attachment for current/past treatment plans, including medications.    Date					
Date Treatment Plan Medications  Current Freatment Plan Plan  Past Freatment Plan  as the patient shown improvement with current treatment plan?  Yes Level of improvement? Fair Moderate Good Excellent  No  escribe the prognosis for the patient's disabling condition:  Over next 12 months:					
escribe the current and past treatment plans, including medications:  See attachment for current/past treatment plans, including medications.  Date Treatment Plan Medications  Past Treatment Plan  Past Treatment Plan  Plan  Past Treatment Plan  Plan  Past Treatment Plan  Plan  Past Treatment Plan  Possible Treatment Pla	linical findings that suppo	rt disabling condition:		<u> </u>	
escribe the current and past treatment plans, including medications:  See attachment for current/past treatment plans, including medications.  Date Treatment Plan Medications  Past Treatment Plan  Past Treatment Plan  Plan  Past Treatment Plan  Plan  Past Treatment Plan  Plan  Past Treatment Plan  Possible Treatment Pla					
Date Treatment Plan Medications  Current Freatment Plan Plan  Past Freatment Plan  as the patient shown improvement with current treatment plan?  Yes Level of improvement? Fair Moderate Good Excellent  No  escribe the prognosis for the patient's disabling condition:  Over next 12 months:	aboratory and diagnostic t	ests relevant to disabling cond	ition:		
Date Treatment Plan Medications  Current Freatment Plan  Past Treatment Plan  as the patient shown improvement with current treatment plan?  Yes Level of improvement?					
Date Treatment Plan Medications  Current Freatment Plan  Past Freatment Plan  as the patient shown improvement with current treatment plan?  Yes Level of improvement?					
Past Freatment Plan  Plan  as the patient shown improvement with current treatment plan?    Yes Level of improvement?   Fair   Moderate   Good   Excellent   No  escribe the prognosis for the patient's disabling condition:  Over next 12 months:		Tor current past treatment pla	ns, including medications.		
Past Treatment Plan  as the patient shown improvement with current treatment plan?  Yes Level of improvement?		e -	Treatment Plan	Med	ications
Past reatment Plan  as the patient shown improvement with current treatment plan?  Yes Level of improvement? Fair Moderate Good Excellent  No escribe the prognosis for the patient's disabling condition:  Over next 12 months:	reatment				
as the patient shown improvement with current treatment plan?    Yes Level of improvement?   Fair   Moderate   Good   Excellent   No  escribe the prognosis for the patient's disabling condition:  Over next 12 months:	Pian 				
as the patient shown improvement with current treatment plan?  Yes Level of improvement? Fair Moderate Good Excellent  No escribe the prognosis for the patient's disabling condition:  Over next 12 months:					
☐ Yes Level of improvement? ☐ Fair ☐ Moderate ☐ Good ☐ Excellent ☐ No escribe the prognosis for the patient's disabling condition:  Over next 12 months:					
☐ Yes Level of improvement? ☐ Fair ☐ Moderate ☐ Good ☐ Excellent ☐ No escribe the prognosis for the patient's disabling condition:  Over next 12 months:	reatment				
No lescribe the prognosis for the patient's disabling condition:  Over next 12 months:	reatment				
escribe the prognosis for the patient's disabling condition:  Over next 12 months:	reatment Plan as the patient shown impr			ont	
Over next 12 months:	reatment Plan  as the patient shown impr			ent	
Long-term:	as the patient shown impr	mprovement? 🗖 Fair 🗖 Mo	oderate 🗖 Good 🗖 Excelle	ent	
	as the patient shown improved as the	mprovement?	oderate		

■ Assessment attached

	Describe Capabilities	Level of Impairment		
Ability to comprehend and follow instructions		☐ None ☐ Slight ☐ Moderate ☐ Marked		
Ability to perform simple and repetitive tasks		□ None □ Slight □ Moderate □ Marked		
Ability to maintain a work pace appropriate to a given workload		□ None □ Slight □ Moderate □ Marked		
Ability to perform complex or varied tasks		□ None □ Slight □ Moderate □ Marked		
Ability to relate to other people beyond giving and receiving instructions		□ None □ Slight □ Moderate □ Marked		
Ability to influence people		□ None □ Slight □ Moderate □ Marked		
Ability to make generalizations, evaluations or decisions without immediate supervision		☐ None ☐ Slight ☐ Moderate ☐ Marked		
Ability to accept and carry out responsibility for direction, control and planning		□ None □ Slight □ Moderate □ Marked		
In your opinion, based on your knowledge, personal contact, and observation of your patient, what type of work and work environments would be conducive for your patient to return to work?				

■ Assessment attached

Please address all below	Indicate MAXIMUM capacity in pounds	Not applicable	OCCASIONAL 0 to 2.6 hours per day	FREQUENT 2.7 to 5.3 hours per day	CONSTANT 5.4 to 8.0 hours per day
Low lift (floor to knuckle)					
Mid lift (knuckle to shoulder)					
Full lift (floor to shoulder)					
Carrying					
Pushing					
Walking					
Climbing	-				
Balancing					
Stooping					
Kneeling					
Crouching					
Crawling	-				
Reaching (immediate)	-				
Reaching (overhead)					
Handling					
Fingering					
Feeling					
Sitting					
Standing					

## Physical Capacity

Please indicate your patient's physical capacity based on the definition in the **Department of Labor's Dictionary of Occupational Titles**: Medium **Sedentary** Sedentary work involves lifting no more than 10 pounds at a time and Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a someone can do medium work, we determine that they can also certain amount of walking and standing is often necessary in carrying out do sedentary and light work. job duties. Jobs are sedentary if walking and standing are required ☐ Heavy occasionally and other sedentary criteria are met. Heavy work involves lifting no more than 100 pounds at a time with Light frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, we determine that they can also do Light work involves lifting no more than 20 pounds at a time with medium, light, and sedentary work. frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting **Very Heavy** most of the time with some pushing and pulling of arm or leg controls. Very heavy work involves lifting objects weighing more than 100 pounds To be considered capable of performing a full or wide range of light at a time with frequent lifting or carrying of objects weighing 50 pounds work, you must have the ability to do substantially all of these activities. If or more. If someone can do very heavy work, we determine that they can someone can do light work, we determine that they can also do also do heavy, medium, light and sedentary work. sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time. Medical provider's signature This statement may be signed only by a practicing physician, physician assistant, psychologist, nurse practitioner (APRN), chiropractor or podiatrist. I, the undersigned, a practicing physician, physician assistant, psychologist, nurse practitioner (APRN), chiropractor or podiatrist duly registered under the laws of the state in which I practice, do hereby certify that my answers to the foregoing guestions are true and complete to the best of my knowledge, information and belief. \_\_\_\_\_ Specialty \_\_\_\_\_ Name \_\_\_\_\_ Please print name Signature \_\_\_\_\_ Medical title \_\_\_\_ Date Phone number Fax number Primary office contact name \_\_\_\_\_ Primary office contact title \_\_\_\_\_\_ Phone # if different from above \_\_\_\_\_ Street address \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ ABMS Board Certified Yes No Toll-free: 1.800.657.5757 Minnesota State Retirement System Mail or fax the completed form to: 60 Empire Drive, Suite 300 St. Paul. MN 55103-3000

Fax: 651.227.5337