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.**

Name of Member (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Position/Occupational Title | 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.

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

Section 3 — Examination Findings

Please provide history of patient's illness/injury.

Chief Complaints

Subjective Symptoms

Height | Weight | Blood Pressure

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

Objective Examination Findings 1

Diagnostic Test – Dates and Findings

Restrictions/Limitations, if so specify.

Diagnosis 2

Objective Examination Findings 2

Diagnostic Test – Dates and Findings

Restrictions/Limitations, if so specify.

Comments

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

Your Name | 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.

   _____

   _____

   _____

   _____

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

Address

City | State | ZIP

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

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