

**PHYSICIAN'S STATEMENT  
APPLICATION FOR DISABILITY RETIREMENT**

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**PART I - MEMBER (PATIENT) INFORMATION (COMPLETE THIS PART BEFORE GIVING IT TO YOUR PHYSICIAN)**

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MEMBER'S NAME (Last)	First Name	M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER
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ADDRESS

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**PART II - GENERAL INFORMATION (To Physician)**

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The individual identified above is requesting medical documentation that will be evaluated along with non-medical documentation, in connection with his/her application for a disability retirement from the Connecticut Municipal Employee's Retirement System (CMERS). A member of CMERS is eligible for a disability retirement benefit when he or she "becomes permanently and totally disabled from engaging in any gainful employment in the service of the municipality". "To be eligible for a disability retirement, the member must show that he or she is permanently and totally disabled from being able to work at least 20 hours per week on a regular basis in any employment capacity for the employer - not just the member's own occupation.

Disability retirement determinations are made in accordance with CMERS retirement regulations. A member is entitled to disability retirement benefits only when the information submitted with the application shows that he or she meets these requirements.

It is important that you respond to every item listed on this Physician's Statement. If an item is not applicable to the member's medical condition, enter "Not Applicable." Enclose this Physician's Statement with the requested reports and any attachments in a sealed envelope marked "Medical Disability - Privilege-Private." send the envelope to the address shown below. You may, if you wish, give it directly to the member (your patient) for delivery to the appropriate office.

Connecticut Municipal Employees Retirement System  
55 Elm Street - 2nd Floor  
Hartford, CT 06106  
**"Medical Disability - Privileged-Private."**

**The member (your patient) is responsible for any costs incurred in connection with providing this documentation to CMERS not send bills for service or copies to CMERS!**

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**PART III - MEDICAL DOCUMENTATION**

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*Please include sufficient details of history, physical findings, diagnostic findings, clinical course of treatment, therapy and response to therapy which will enable a reviewing physician to make an independent determination as to the severity, type and duration of the illness, injury or impairment. Your office needs to provide copies of:*

1. All medical records which include but are not limited to correspondence to and from the member (your patient) and other doctors, discharge summaries, detailed information regarding the symptoms and history, past and current physical findings, consults, outpatient reports, reports of all applicable diagnostic laboratory tests (e.g. hematologic, chemistry, electrophysiological, radiologic, etc.), results of mental status examinations, personality tests, tests of cognitive function, neuropsychiatric tests, office and treatment notes, worker's compensation documents and any information related to psychological, psychiatric, and drug and alcohol treatment records.
2. Diagnosis of patient's condition(s) and an assessment of the degree to which the medical condition(s) has or has not become static and an estimate of the expected date of full or partial recovery or remission.
3. If restrictions have been placed on this patient's activities, please state what they are, why they have been imposed, and how long you expect these to be in effect.

***If you need more space in any section, attach a separate sheet and indicate that an attachment is provided.***

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**PART IV - PATIENT INFORMATION**

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- A. **HISTORY** - Give chief complaints, past and present, dates of first and most recent examinations and frequency of visits
- B. **PHYSICAL FINDINGS** - Please list all pertinent findings (with dates).
- C. **LABORATORY FINDINGS AND DIAGNOSTIC DATA** - Give results of all pertinent studies and key tests.
- D. **DIAGNOSIS** - If this pertains to a Psychiatric Review - please note the GAF scale.
- E. **TREATMENT AND RESPONSE**
1. Please include all non-surgical therapeutic interventions and all surgical treatments and outcomes.
  2. Has the condition(s) changed over-time (i.e. course of disorder)? If yes, please describe how and over what time frame:

- F. **REASONABLE ACCOMMODATION** - Are there any accommodations your patient can request from his/her employer that would permit him or her to continue to perform the essential functions of the job? If yes, please describe.
- G. **EVALUATION** - If restrictions have been placed on this patient's activities, please state what they are and why they have been imposed. Please provide a short narrative as to: (1) the member's impairment(s); (2) any functional restrictions or limitations that exist as a result of that impairment; (3) and how long these restrictions may last if known.
- H. **PROGNOSIS** - Stable or plateau, likely to regress, likely to resolve.
- I. **ASSESSMENT:** A member of the CMERS retirement system is entitled to disability retirement benefits only when he or she is (1) *permanently* disabled and (2) *totally* disabled from (3) engaging in *any* gainful employment (ability to work at least 20 hours a week in any employment capacity). In your estimation, does your patient's present condition clearly come within all three foregoing provisions? If yes, please provide the medical basis for your assessment touching upon all three criteria.

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**PART IV - PHYSICIAN SIGNATURE**

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I, the undersigned physician, understand that \_\_\_\_\_ has applied for a disability retirement benefit pursuant to the provisions of Connecticut Municipal Employees Retirement System. I certify that I have read and understand the information contained in this statement, and subscribe, under the penalties of perjury, that the information I have supplied in this statement is true, complete, and correct to the best of my knowledge.

Physician's name: \_\_\_\_\_ Degree: \_\_\_\_\_

Address: \_\_\_\_\_

Specialty: \_\_\_\_\_ CT License Number: \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date