

State of New Jersey — Department of the Treasury
Division of Pensions and Benefits • PO Box 297 • Trenton, NJ 08625-0297 • (609) 292-7524

MEDICAL EXAMINATION BY PERSONAL OR TREATING PHYSICIAN

This form must be filed in support of an *Application for Disability Retirement* and is restricted to the confidential use of the retirement system.

PART ONE — APPLICANT (COMPLETE PART ONE BEFORE PRESENTING THIS FORM TO THE PHYSICIAN.)

Name: _____ Date of Birth: _____
Last, First, Middle Initial Month, Day, Year

Social Security Number: _____ Member Number: _____

Job Title: _____

PART TWO — PHYSICIAN (PLEASE TYPE OR PRINT CLEARLY.)

Please complete this form in its entirety. You may include copies of office notes to provide additional documentation but **each question must be answered on this form.** An incomplete form will be returned to the member and will delay processing of the application.

1. Treating member since _____ to _____
Month, Day, Year Month, Day, Year

2. Date of last physical examination _____ (Please attach a copy of the examination results.)
Month, Day, Year

3. How long have you been treating the member for the accident, injury, or condition that directly relates to their disability? From _____ to _____
Month, Day, Year Month, Day, Year

4. Physical Findings:

5. Related laboratory, cardiographic, x-ray or other diagnostic data: (Please attach copies of narrative reports. No films please.)

6. Diagnosis:

7. Have you treated the member for this condition before the member was considered disabled?

NO YES (If YES, please indicate treatment and results of that treatment.)

8. Is the applicant now totally and permanently disabled and no longer able to perform his or her job duties and/or any other job?

NO YES (If YES, please explain in what way the applicant's symptoms or physical findings prevent him or her from working.)

9. a) Is the applicant's disability likely to be stable or progressive? STABLE PROGRESSIVE

b) If progressive, is death imminent? NO YES

c) Is there a possibility that the applicant might improve to a degree to perform the applicant's job duties? NO YES

10. Is the applicant permanently and totally disabled as a direct result of an accident that occurred during the performance of the applicant's regular assigned duties?

NO YES (If YES, please explain the casual relationship)

(PLEASE TYPE OR PRINT CLEARLY.)

Physician's Name: _____ Degree: _____

Address: _____

_____ Phone: (____) _____

Specialty: _____ NJ License Number: _____

Signature of Physician

Date