



NEW YORK STATE TEACHERS' RETIREMENT SYSTEM
10 Corporate Woods Drive, Albany, NY 12211-2395
(800) 348-7298, Ext. 6010; Fax (518) 431-8797

OFFICE SERVICES ONLY

MEDICAL REPORT

PART 1 (To Member): This section must be completed by you and forwarded to your physician.

Patient Name and Address	EmpID or Social Security Number	Date of Birth
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Physician Name	Physician Address
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I hereby authorize and direct any physician, hospital, medical records facility or any other party to disclose to the New York State Teachers' Retirement System all information which they may possess including, but not limited to, diagnosis, treatments rendered, x-rays, and copies of all hospital and medical records which are in their possession, and further, I waive any claim of privilege in respect thereto. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Applicant: _____ **Date** _____

PART 2 (To Physician): Your patient applied for disability retirement from this System. Benefits will not be granted until we receive complete documentation of the person's illness.

- Please provide all of the following:
- ◆ Answers to the questions listed below.
 - ◆ A narrative description of the person's illness (the reverse side of this form is provided for this purpose).
 - ◆ Copies of any pathological and x-ray reports, CAT scans, MRI's, operation notes, psychological and neurological evaluations and any previously prepared reports that clearly outline the history of the person's illness.

Date you first treated this patient: _____

Date the disability began: _____

Date you last saw this patient: _____

Is this patient totally and permanently disabled for performing the duties of a teacher? Yes No

If yes, please explain why: _____

Is this patient totally and permanently disabled for performance of gainful employment? Yes No

If yes, please explain why: _____

Physician's Signature: _____ **Date:** _____

Physician's Name (printed): _____

Specialty, if any: _____ **Date of Board Certification:** _____

**** SEE REVERSE SIDE ****

PART 3 (To Physician): Provide a narrative description of the person's illness including:

- ◆ a history
- ◆ treatment received and the result
- ◆ diagnosis
- ◆ prognosis

Please type or print clearly

STANDARD FOR DETERMINING DISABILITY RETIREMENT

In order for a member to be entitled to disability retirement, it must be determined that the member is totally and permanently disabled and that member was so disabled at the time he or she ceased performance of duties. To be deemed totally disabled it must be concluded that the member is physically or mentally incapacitated for the performance of gainful employment. Gainful employment shall be physical and/or mental activity which a member is regularly able to engage in as a means of earning a living. To be deemed permanently disabled, the condition must be such to justify a deduction that the end of the disability cannot be foreseen for at least one year. In addition, total disability is not permanent if, during the period for which recovery is sought or at any time thereafter, the member may alleviate or control the condition by availing himself or herself of a standard treatment which is not inherently dangerous. The member shall have the burden of establishing all of the foregoing to the satisfaction of the Retirement Board.

Physician's Signature: _____ **Date:** _____

Physician's Name (Printed): _____

Specialty, if any: _____ **Date of Board Certification:** _____