RET-54.3 (9/22)

OFFICE SERVICES ONLY

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

MEDICAL REPORT

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

Patient's Name and Address	EmplID or Social Security Number	Date of Birth

Physician's Name	Physician's Address

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 initial any alterations made during the completion of this form.*

Date you first treated this patient: _____

Date the disability began: _____

Date you last saw this patient: _____

Is this patient **totally**** disabled from the performance of <u>all</u> gainful employment? ☐ Yes ☐ No

Please explain why, including Activities of Daily Living/IADLs (if applicable): _____

_____

_____

Is this patient **permanently**** disabled from the performance of <u>all</u> gainful employment? ☐ Yes ☐ No

Please explain why, including Activities of Daily Living/IADLs (if applicable): _____

_____

_____

Please provide copies of any surgical or pathology reports, diagnostic test results (including X-ray, MRI, and CAT scan reports), psychological and neurological evaluations, and any reports and progress notes that clearly outline the history of the person's illness.

THESE FORMS ARE CRITICAL TO PRESENTING A PATIENT'S FILE. IF YOU DO NOT HAVE ACCESS TO THE ABOVE RECORDS, PLEASE FORWARD THIS FORM TO YOUR MEDICAL RECORDS DEPARTMENT OR FACILITY AFTER SIGNING/ DATING.*

Physician's Specialty, if any: _____ Date of Board Certification: _____

Physician's Name (Printed): _____

Physician's Signature: _____ Date: _____

****SEE PART 3 FOR NARRATIVE AND STANDARDS****

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 they ceased performance of duties.
- **To be deemed totally disabled** it must be concluded that the member is physically or mentally incapacitated from 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 themselves 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 Specialty, if any: _____ Date of Board Certification: _____

Physician's Name (Printed): _____

Physician's Signature: _____ Date: _____