PERA
Public Employees
Retirement Association
of New Mexico

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EXAMINING PHYSICIAN'S STATEMENT FOR APPLICATION FOR DISABILITY BENEFITS FORM

Instructions: Please print or type in dark ink. The original of this form must be completed in its ENTIRETY and returned to PERA for processing. ENTERING "SEE ATTACHED" IS NOT SUFFICIENT. A brief explanation MUST be on this form.

Information Needed from the Health Care Provider

The member named below is applying for PERA disability retirement. To be considered, PERA must receive a complete medical and/or psychological history and report on him/her. In addition, please send a copy of all medical or psychological records relating to examinations or treatments relating to this applicant's claim for disability retirement, *especially as they relate to the claimant's ability to work*.
If available, include office notes, laboratory test results, hospital history, physical history, discharge summary, ability to work and X- ray, pathology and consultation reports. Please include medical information that is current within 3 months from date of application. **The member is responsible for providing all medical documentation and current doctor's narratives to PERA.**

Please type or print so that others can read this information. Attach additional sheet(s) if necessary.

1. Name of Claimant _____
2. Social Security Number | | | | – | | | – | | | | |
3. Height _____ Weight _____
4. Date present illness, injury or condition began _____
5. A brief explanation of previous relevant history of illness, injury or condition _____

_____

_____

_____

6. A brief explanation of contributing causes to present illness, injury or condition, if any _____

_____

_____

_____

7. Do you consider this disability to have occurred as the result of causes arising solely and exclusively out of and in the course of the claimant's employment? Yes ____ No ____
   If yes, A brief explanation of why? _____

   _____

8. A brief explanation of symptoms _____

   _____

   _____

9. A brief explanation of diagnosis _____

10. A brief explanation of objective findings (*attach copies of relevant test results*) _____

    _____

Name of Claimant _____ Social Security Number _____

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11. A brief explanation of treatment plan and medications _____

12. Describe the claimant's functional limitations (i.e. mobility, dexterity, attitude, etc as to employment and/or activities or daily living.)_____

13. Please attach any applicable reports referenced in #12 above. (i.e. functional capacity evaluation, PT notes, etc.)

14. A brief explanation of expected duration of restrictions _____

15. Type of work claimant is presently capable of performing

_____ No Work.

_____ Sedentary Work. May include lifting 10lbs. And occasionally lifting or carrying such articles as dockets, ledgers and small tools. Job is primarily done sitting, and only occasional walking and standing are required.

_____ Light work. May include lifting 20lbs. maximum, with frequent lifting and/or carrying objects weighing up to 10lbs. Job requires walking or standing to a significant degree, or involves sitting most of the time with a degree of pushing or pulling of arm and leg controls.

_____ Medium work. May include lifting 50lbs. maximum with frequent lifting and/or carrying objects weighing up to 25 lbs.

_____ Heavy work. May include lifting 100lbs. maximum with frequent lifting and/or carrying objects weighing up to 50 lbs.

_____ Very heavy work. Lifting object in excess of 100lbs. with frequent lifting and/or carrying objects weighing 50 lbs. or more.

_____ Other (*Describe*) _____

16. Has the claimant reached maximum medical improvement? _____ When do you estimate the claimant will reach maximum medical improvement? _____

17. If claimant is <u>not</u> presently capable of performing any gainful employment, will claimant be able to return to some type of employment? Yes _____ No _____ If yes, approximate date _____
Explain _____

Name of Claimant _____ Social Security Number _____

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18. What permanent restrictions, if any, do you believe claimant will have? _____

19. Will the claimant likely be capable of returning to his or her regular occupation? Yes ____ No ____
    If Yes, approximate date _____
    Explain: _____

20. Are you able to give this claimant a social security impairment rating? Yes ____ No ____
    as to regular occupation _____ %
    as to any gainful employment _____ %
    If not, a brief explanation of why not? _____

(Print or type)

21. Have you evaluated claimant's functional capacities? _____ If so, please attach report.

This form must be signed by a medical doctor (M.D.), psychologist (Ph.D.) or psychiatrist (M.D.) or doctor of osteopathic medicine (D.O.) per PERA rule 2.80.1000.30 A.(2)

Date _____ Signature _____

Print Name _____

Address _____

Phone _____

Fax _____