PRINT

ICERS
IMPERIAL COUNTY EMPLOYEES' RETIREMENT SYSTEM
www.icers.info

PHYSICIAN STATEMENT FOR DISABILITY RETIREMENT

PATIENT'S NAME: _____

Dear Doctor:

This member of the Imperial County Employees' Retirement System (ICERS) has applied for a disability retirement. The member must present medical evidence from a physician pertaining to the disabling illness or injury in connection with the application. Your completed Physician Statement will be included in the package of information sent to the Board of Retirement's physician.

Your evaluation should determine if the member can perform the particular duties as outlined in the job description. The member will provide you a copy of the job description. **To be considered disabled under Retirement Law, the member must be permanently disabled AND unable to perform a substantial portion of the tasks of his/her County job.**

PLEASE DO NOT ATTACH AN EARLIER NARRATIVE REPORT IN LIEU OF FILLING OUT THIS FORM. Please complete and sign the Physician Statement, and attach the job description. Return them to the patient. Failure to fill out the form completely will cause the application to be rejected.

If you have any questions, please call ICERS' Disability Retirement department at (442) 265-7539.

Sincerely,

Retirement Administrator

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PHYSICIAN STATEMENT FOR DISABILITY RETIREMENT

PATIENT'S NAME: _____

SOCIAL SECURITY NO: _____

1. The patient is (check one):
   - ☐ Permanently and substantially incapacitated
   - ☐ Temporarily incapacitated for a substantial portion of the duties as a _____ as outlined in the attached Employer's Job Description.

2. What is your diagnosis(es)?

   _____
   _____
   _____
   _____

3. What objective findings support your diagnosis(es)?

   _____
   _____
   _____
   _____

4. What are the symptoms related to this illness/injury?

   _____
   _____
   _____
   _____

5. When and how did the symptoms first appear?

   _____
   _____
   _____
   _____
   _____
   _____

6. What functions of the job can the patient **NOT PERFORM**? Why? (Please be specific.)

_____
_____
_____
_____
_____
_____

7. Will the patient's condition improve enough to return to work? (Please explain your answer in detail.)

_____
_____
_____
_____

8. Based on your medical opinion, do you feel the patient's incapacity is the result of a job-related injury, illness or disease? (Please be specific.)

_____
_____
_____
_____
_____

9. I am the patient's: ☐ Treating Physician ☐ Examining Physician

I hereby certify the Physician's Statement is based on my examination and the attached Job Description of the patient's duties.

_____ _____
Signature Date

Name: _____

Address: _____

Telephone No: _____

Licensed to practice medicine under the Laws of the State of California as
Doctor of _____.
Specialty: _____

<u>NOTE:</u> This form must contain the original signature of the physician to be valid. A stamped signature will not be accepted.