Physician's Statement

MEMBER INFORMATION

This section is to be completed by the member who is applying for disability retirement with the Texas County & District System.

First Name	Middle Name	Last Name	Birth Date	Social Security Number

Employer Name	Phone Number	Email Address

Mailing Address	City	State	Zip Code

MEMBER AUTHORIZATION

I am the member of the Texas County & District Retirement System (TCDRS) whose name appears above. I authorize my attending physician who examined me to disclose information related to my medical condition. I consent that the information provided is complete and true to the best of my knowledge and is made for the purpose of applying for disability retirement benefits from TCDRS.

Member's Signature	Date
X	

The following sections to be filled out by physician.

PHYSICIAN INFORMATION

Physician Name	Physician Specialty	License Number

Graduated From	Graduation Year	Name of Practice

Mailing Address

City	State	Zip Code	Phone Number

NOTE TO PHYSICIAN:

All medical information is for interpretation by actively practicing physicians to determine your patient's disability status according to provisions of the Texas County & District Retirement System Act.

Documentation is required, so please include photocopies of a current history and physical, hospital discharge summary, narrative report or comprehensive consultation, and other pertinent information. Please be sure the attached information contains references to all items below.

Thank you for this consideration.

Texas County & District Retirement System Medical Board

Any corrections or whiteouts must be initialed.

Physician's Statement

MEDICAL CONDITION(S)

Height	Weight	Blood Pressure	Pulse	Respiration	Temperature

1. a. What is your diagnosis of the condition(s)? **Please provide medical documentation.**

b. Date of onset: _____ First visit for the condition(s): _____

c. Please describe the etiology of the diagnosed condition(s).

d. Please describe the severity and course of the condition(s).

e. What treatment was prescribed and how has the patient responded to treatment?

f. Please include any other significant information/remarks/insights.

2. Give **abnormal** findings in regard to the following. **Please provide medical documentation.**

a. Head, Neck and ENT: _____

b. Chest: _____

c. Heart: _____

d. Abdomen: _____

e. Extremities: _____

Any corrections or whiteouts must be initialed.

Physician's Statement

f. Neurological: _____

_____

g. Psychiatric: _____

_____

h. Laboratory: _____

_____

i. Other special tests: _____

_____

3. Describe physical limitations of patient:

_____

_____

4. Describe mental limitations of patient:

_____

_____

5. List all additional diagnoses or medical conditions of this patient. **Please provide medical documentation.**

_____

_____

PHYSICIAN CERTIFICATION

According to the provisions of the Texas County & District Retirement System Act, a member of TCDRS is entitled to disability retirement benefits provided that (1) the member is mentally and/or physically incapacitated to engage in **any** gainful occupation, and (2) the incapacity is likely to be permanent.

1. In your opinion, does the member's present condition clearly come within the foregoing provision? ☐ **Yes** ☐ **No**

2. Is the incapacity due to an injury sustained during the performance of duty for a TCDRS participating employer? ☐ **Yes** ☐ **No**

PHYSICIAN AUTHORIZATION

I certify that the above statements and answers consisting of the consecutively numbered pages were made by me, and that statements and answers are each and all complete and true to the best of my knowledge. I will provide documentation to support these statements and answers.

Name of Attending Physician	Signature of Attending Physician	Date Signed

Any corrections or whiteouts must be initialed.