Member's Statement on Disability

MEMBER INFORMATION

First Name	Middle Name	Last Name	Birth Date	Social Security Number
Mailing Address		City	State	Zip Code
Phone Number	Email Address		TCDRS Account Number	

EMPLOYMENT INFORMATION

Please provide your current TCDRS employer's information and your current job title and description, and provide details about any other current or past employment.

Employer Name		City	Hire Date
Current Job Title	Past Position(s)		
Please provide your job description, including specific activities and responsibilities.			
Please list all previous work experience, including job titles and descriptions.			
Please list any other gainful employment (activities you currently pursue or have pursued in the past).			

MEDICAL CONDITION(S)

Please provide the following information about your diagnosed medical conditions. Be sure to send **supporting documentation**.

Diagnosis			Date of Onset	Date of Diagnosis
Attending Physician Name	Physician Specialty	Name of Practice		Phone Number
Mailing Address		City	State	Zip Code
Please describe the cause of this medical condition.				
Please describe the symptoms and limitations of this medical condition.				
Have you ever had the same, similar or related problem at any time in the past? ☐ Yes ☐ No (If yes, please provide the diagnosis, date and cause of onset, and symptoms).				
Please list any other diagnosed medical conditions that contribute to your incapacity.				

You may write on the back of this form or include additional information as an attachment. Any corrections or whiteouts must be initialed.

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HOSPITALIZATIONS AND OPERATIONS

Please list all hospitalizations and operations related to your medical condition, if applicable.

Hospital	Medical Condition		
Treatment or Operation		Date Admitted	Date Discharged
Hospital	Medical Condition		
Treatment or Operation		Date Admitted	Date Discharged
Hospital	Medical Condition		
Treatment or Operation		Date Admitted	Date Discharged

OTHER PHYSICIANS

Please provide the following information about any other physicians consulted for this diagnosed medical condition.

Physician Name	Physician Specialty	Name of Practice		Phone Number
Mailing Address		City	State	Zip Code
Physician Name	Physician Specialty	Name of Practice		Phone Number
Mailing Address		City	State	Zip Code
Physician Name	Physician Specialty	Name of Practice		Phone Number
Mailing Address		City	State	Zip Code

MEDICATIONS

Please list all **current** medications related to your medical condition.

Medication	Purpose	Prescribing Doctor	Date Prescribed
Medication	Purpose	Prescribing Doctor	Date Prescribed
Medication	Purpose	Prescribing Doctor	Date Prescribed
Medication	Purpose	Prescribing Doctor	Date Prescribed
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ADDITIONAL INFORMATION

Please describe how you were injured, including the date, location and circumstances of the injury.
Have you followed all your doctor's recommendations? If not, please explain.
Do you feel like your condition is improving, the same, or worsening?
Please list activities (home or elsewhere) that you participate in now.
Which activities are you unable to do because of this condition?
Please give any other facts or medical information you feel would support your request for disability retirement.

EDUCATION HISTORY

Please indicate your level of education and training, including institution names and degree focuses:

a. Elementary and middle school _____

b. High school _____

c. College _____

d. Specialty school (specify) _____

e. Technical school (specify) _____

MEMBER CERTIFICATION

By signing below, I certify that I am the TCDRS member named above and that the information I have provided is true and correct to the best of my knowledge and belief.

Notice to persons signing this statement: Section 841.101 of the Texas Government Code provides for punishment by fine and/or imprisonment of (i) a person who knowingly makes a false statement in a report or application to TCDRS in an attempt to defraud the system or (ii) a person who knowingly makes a false certificate of an official report to the system.

Member's Signature	Date
X	

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