BD-1177-0826

State of New Jersey • Department of the Treasury

PFRSNJ DISABILITY RETIREMENTS

P.O. Box 297, Trenton, NJ 08625-0297

MEDICAL EXAMINATION BY PERSONAL OR TREATING PHYSICIAN

All questions must be answered. Altered forms will not be accepted.

This form must be filed in support of an *Application for Disability Retirement* and is restricted to the confidential use of the retirement system.

PART ONE — APPLICANT INFORMATION (To be completed by the member before presenting to the physician)

1. Name _____ (*Last* / *First* / *Middle Initial*) 2. Date of Birth _____/_____/_____

3. Social Security Number _____ 4. Member Number _____

5. Job Title _____

PART TWO — PATIENT INFORMATION (To be completed by the treating physician)

Please complete this form in its entirety. You may include copies of office notes to provide additional documentation but each question must be answered on this form. An incomplete form will be returned to the member and will delay processing of the application.

6. a.) Treating member since _____/_____/_____ (*Date*) to _____/_____/_____ (*Date*)

   b.) Frequency of visits_____ c.) Is the member a regular patient? ☐ Yes ☐ No

7. Date of last physical examination _____/ _____/ _____ (*Date*) (Please attach a copy of the examination results)

8. How long have you been treating the member for the accident, injury, or condition that directly relates to their disability?

   From _____/_____/_____ (*Date*) to _____/_____/_____ (*Date*)

9. Physical Findings/Diagnosis:

10. Related laboratory, cardiographic, x-ray or other diagnostic data: (Please attach copies of narrative reports - no films please)

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11. Have you treated the member for this condition before the member was considered disabled?

☐ Yes ☐ No (If yes, please indicate treatment and results of that treatment)

12. Is the applicant now totally and permanently disabled and no longer able to perform his or her assigned job duties?

☐ Yes ☐ No (If yes, please explain how the applicant's symptoms or physical findings prevent him or her from working)

13. a.) Is the applicant's disability likely to be stable or progressive? ☐ Stable ☐ Progressive

b.) If progressive, is death imminent? ☐ Yes ☐ No

14. Is the applicant permanently and totally disabled as a direct result of an accident that occurred during the performance of the applicant's regular assigned duties?

☐ Yes ☐ No (If yes, please explain the causal relationship)

Physician's Name _____ Degree _____

Address _____
Street *City* *State* *Zip Code*

Phone Number _____

Specialty _____ N.J. License Number _____

_____ _____/_____/_____
Signature of Physician *Date*