Attending Physician's Report of Disability

Tennessee Consolidated Retirement System
502 Deaderick Street
Nashville, Tennessee 37243-0201
1-800-770-8277 ◆ treasury.tn.gov/tcrs

ATTENTION APPLICANT AND PHYSICIAN:

- This is an authorization requested by the applicant in order that discussion of any and all information concerning the applicant's disability may be freely given to the TCRS.
- The expense of furnishing this information must be paid by the applicant.
- In addition to the completion of this form, the physician is requested to attach all office notes, hospital summaries, test results and any other medical information available.

SECTION 1. MEMBER INFORMATION

Member ID	Last 4 SSN XXX-XX-	Date of Birth
Full Name		Gender ☐ Male ☐ Female
Mailing Address		
City	State	Zip Code
Email		Phone Number
Applicant's Signature		Date

SECTION 2. TO BE COMPLETED BY PHYSICIAN *(Complete only the parts that are applicable. Give results or descriptions.)*

Physician's Full Name				
Physician's Mailing Address				
City	State	Zip Code	Phone Number	
Patient's Current Height	feet	inches	Patient's Current Weight	Pounds

When were you first consulted regarding the present illness?

Are you currently attending the applicant? ☐ Yes ☐ No

If not, please indicate the reason why you are no longer attending the applicant:

SECTION 2. TO BE COMPLETED BY PHYSICIAN *(Complete only the parts that are applicable. Give results or descriptions.)*

Diagnosis of Primary Impairments:

Diagnosis of Secondary Impairments:

Musculoskeletal System:

X-Ray Findings:

Limitation of Motion and the Degree:

Comment on History of Pain, Swelling and Stiffness:

Respiratory System:

Chest X-Ray Findings

Pulmonary Function / Arterial Blood / Gas Studies:

In the Case of Pulmonary Tuberculosis, Provide Sputum Culture Results:

Cyanosis / Dyspnea:

SECTION 2. TO BE COMPLETED BY PHYSICIAN *(Complete only the parts that are applicable. Give results or descriptions.)*

Cardiovascular System:

EKG / Enzyme Studies:

Blood Pressure Readings:

Chest X-Ray, Including Cardio-Thoracic Ratio:

Chest Pain and Medication Used to Relieve Pain:

Edema, Pigmentation, Cyanosis or Ulceration:

End-Organ Damage as a Result of Hypertension:

Indicate New York Heart Classification:

Mental Disorders:

Impairment of Memory, Judgment/Ability to Perform Calculations:

Reduction in Daily Activities, Interests, Personal Habits and Ability to Relate to Others:

Does the Applicant Demonstrate the Ability to Relate to and Communicate with Supervisors and Co-Workers in a Work Situation? ☐ Yes ☐ No

Explain:

SECTION 2. TO BE COMPLETED BY PHYSICIAN *(Complete only the parts that are applicable. Give results or descriptions.)*

Hearing:

Results of Audiological Evaluation (with hearing aid):

Visual:

Best Corrected Visual Acuity and Visual Fields:

Digestive:

Liver Studies, X-Ray Findings, Endoscopy / Barium Enema Studies, Weight Loss:

Genito-Urinary:

BUN / Creatine Clearance, Report of Dialysis Treatment:

Hemic and Lymphatic:

Complete Blood Count:

Endocrine:

Diabetes, Evidence of Neuropathy, Acidosis, Amputations / Ophthalmological Changes:

SECTION 2. TO BE COMPLETED BY PHYSICIAN *(Complete only the parts that are applicable. Give results or descriptions.)*

Neurological:

EEG and Describe Motor Limitations:

Neoplasms:

Biopsy and Operative Reports, Severity and Extent of Lesion:

Prognosis:

Based on your recommended treatment, give degree of improvement that can reasonably be anticipated along with approximate period of time required to achieve this improvement:

The impairment has or is expected to last 12 continuous months? ☐ Yes ☐ No

Has the impairment prevented performance of past work? ☐ Yes ☐ No

Does the impairment prevent engagement in all other gainful employment? ☐ Yes ☐ No

If not, please indicate the type of work the applicant is capable of performing: ☐ Heavy ☐ Medium ☐ Light ☐ Sedentary

Include any hospitalization records, including discharge summary:

Physician's Signature Date