BD-0021-1015

State of New Jersey — Department of the Treasury
Division of Pensions and Benefits • PO Box 295 • Trenton, NJ 08625-0297 • (609) 292-7524

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* (COMPLETE PART ONE BEFORE PRESENTING THIS FORM TO THE PHYSICIAN.)

Name: _____ Date of Birth: _____
Last, First, Middle Initial *Month, Day, Year*

Social Security Number: _____ Member Number: _____

Job Title: _____

PART TWO — *PHYSICIAN* **(PLEASE TYPE OR PRINT CLEARLY.)**

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.

1. Treating member since _____ to _____
Month, Day, Year *Month, Day, Year*

2. Date of last physical examination _____ *(Please attach a copy of the examination results.)*
Month, Day, Year

3. How long have you been treating the member for the accident, injury, or condition that directly relates to their disability?
From _____ to _____
Month, Day, Year *Month, Day, Year*

4. Physical Findings:

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

6. Diagnosis:

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

❒ NO ❒ YES *(If YES, please indicate treatment and results of that treatment.)*

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

❒ NO ❒ YES *(If YES, please explain in what way the applicant's symptoms or physical findings prevent him or her from working.)*

9. a) Is the applicant's disability likely to be stable or progressive? ❒ STABLE ❒ PROGRESSIVE

b) If progressive, is death imminent? ❒ NO ❒ YES

c) Is there a possibility that the applicant might improve to a degree to perform the applicant's job duties? ❒ NO ❒ YES

10. 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?

❒ NO ❒ YES *(If YES, please explain the casual relationship)*

(PLEASE TYPE OR PRINT CLEARLY.)

Physician's Name:_____ Degree: _____

Address:_____

_____ Phone: (_____) _____

Specialty: _____ NJ License Number: _____

_____ _____

Signature of Physician *Date*