



# PHYSICIAN'S STATEMENT – DISABILITY CLAIM

IMRF Form 5.42 (Rev. 02/09) *Please print or type (Use Black Ink)*

*Do not submit this form if the patient is still able to work.*

|                          |                     |                |   |
|--------------------------|---------------------|----------------|---|
| Patient's Last Name      | First               | Middle Initial | Social Security Number<br>____ - ____ - _____ |
| Street (Mailing) Address | City, State and ZIP |                | Phone Number<br>(      )                      |
| Birth date               | Patient's Employer  |                |   |

Diagnosis and concurrent conditions. **(MANDATORY)**  
 ICD 9 Code \_\_\_\_\_

Is condition due to: Injury or sickness arising out of patient's employment?  Yes  No    Pregnancy?  Yes  No  
 Alcoholism?  Yes  No    Narcotic Drugs?  Yes  No    Self-inflicted Injury?  Yes  No

Did you recommend this person stop working?  Yes  No  
 If yes, indicate date \_\_\_\_\_

**Report of Treatments or Services. (Attach copy of office notes)**

| Date | Place (give name and address of hospital) - also list office visits | Description of Surgical or Medical Services Rendered |
|------|---|--|
|      |   |  |
|      |   |  |
|      |   |  |
|      |   |  |

Date of next evaluation: \_\_\_\_\_

Is disability due to an accident?  Yes  No    If yes, date of accident \_\_\_\_\_

|   |  |
|---|--|
| Date symptoms first treated   | Patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>(If yes, when and describe)          |
| Describe any complications  | Patient still under your care? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>(If no, give date services terminated)            |
| Patient was continuously disabled (unable to work) <b>NOTE: Please be advised that this form is INVALID without a "From" Date below</b><br>From _____ Through _____ | Is patient now able to return to work in former position or on a trial work period? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If still disabled, what is principal cause of disability?   | If still disabled, date patient should be able to return to work or be eligible for a trial work period                                      |

**\*Office visit notes/medical records must be attached to completed form.**

|                          |                     |                           |
|--------------------------|---------------------|---------------------------|
| Physician's Signature    |                     | Date                      |
| Physician's Name         | Degree/Specialty    | Telephone Number (      ) |
| Street (Mailing) Address | City, State and ZIP | Fax Number (      )       |
|                          |                     | Email Address:            |