



PHYSICIAN'S STATEMENT – DISABILITY CLAIM

IMRF Form 5.42 (Rev. 05/11)

Please print or type (use Black Ink)

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

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

| | | | |
|--------------------------|-------|---------------------------------|------------------------|
| Patient's Last Name | First | Middle Initial | Social Security Number |
| Street (Mailing) Address | | City, State and ZIP | Phone Number () |
| Birth Date | | Patient's/Employee's Occupation | |

MANDATORY INFORMATION

*This section in the red box **MUST** be completed **fully**. If this information is not provided **the form will not be processed**.*

| | | |
|---|---|--|
| Diagnosis and concurrent conditions. | | |
| ICD 9 Code(s) _____ | | |
| Report of Treatments or Services. (Failure to attach Office Notes will delay processing of this claim.) | | |
| Date | Place (give name and address of hospital) - also list office visits | Description of Surgical or Medical Services Rendered |
| | | |
| | | |
| Date of next evaluation: _____ | | |
| Patient was continuously disabled (unable to work) NOTE: Please be advised that this form is INVALID without a "From" Date below | | |
| FROM _____ THROUGH _____ | | |

| |
|---|
| Is condition due to: Injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is disability due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , date of accident: _____ |
| Did you recommend this person stop working? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , indicate date: _____ |
| Date symptoms first treated _____ Describe any complications: _____ |
| Patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , indicate date(s) and describe: _____ |
| Is patient now able to return to work in full duty capacity or with work restrictions? <input type="checkbox"/> Yes, Full Duty <input type="checkbox"/> Yes, w/Restrictions <input type="checkbox"/> No List any restrictions/limitations: _____ If yes , indicate return date _____ |
| If still disabled, what is principal cause of disability? _____ |

MANDATORY/VALID SIGNATURE, by licensed, practicing physician only.

| | | |
|--|---------------------|----------------------|
| Physician's Signature (NOTE: Form will not be processed without Mandatory/Valid signature.) | | Date |
| Physician's Name | Degree/Specialty | Telephone Number () |
| Street (Mailing) Address | City, State and ZIP | Fax Number () |
| | | Email Address: |

Illinois Municipal Retirement Fund

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