



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 Rowe | First James | Middle Initial J. | Social Security Number 000 — 00 — 0000 |
| Street (Mailing) Address 123 Oak Street | | City, State and ZIP Anywhere, IL 60000-1234 | Phone Number (000) 111-0022 |
| Birth Date June 1, 1962 | | Patient's/Employee's Occupation Maintenance Manager | |

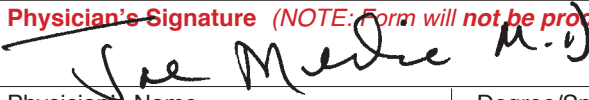
MANDATORY INFORMATION

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) XXXXX00000-0000-0 | | |
| 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 |
| March 2, 2006 | Anywhere Medical Center 123 Linden Street Anywhere, IL 60000 | Open reduction and internal fixtiro of transverse fracture |
| 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 March 2, 2006 THROUGH Present date | | |

| | |
|--|--|
| Is condition due to: Injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| Is disability due to an accident? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | If yes, date of accident: March 1, 2006 |
| Did you recommend this person stop working? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | If yes, indicate date: March 2, 2006 |
| Date symptoms first treated March 2, 2006 Describe any complications: | |
| Patient ever had same or similar condition? <input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> Yes, w/Restrictions <input type="checkbox"/> No | |
| List any restrictions/limitations: Patient is unable to walk without crutches. If yes, indicate return date April 25, 2006 | |
| 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 March 5, 2006 |
| Physician's Name Dr. Joe Medic | Degree/Specialty M.D. | Telephone Number (000) 000-0000 |
| Street (Mailing) Address 123 Pine Street | City, State and ZIP Anywhere, IL 60000 | Fax Number 000) 000-0000 |
| | | Email Address: jmedic@anywhere.com |

Illinois Municipal Retirement Fund

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