PUBLIC SCHOOL RETIREMENT SYSTEM OF MISSOURI

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Jefferson City, MO 65102-0268
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Toll Free: (800) 392-6848
Fax: (573) 634-7934
Email: psrspeers@psrspeers.org
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ATTENDING PHYSICIAN STATEMENT- to be completed by your physician(s)

*Please provide a copy of this statement to all of your treating physicians *

Physician(s) must complete and send this form directly to PSRS with copies of medical and clinical records for the past three years or from the onset of the medical condition, whichever is longer.

It is your responsibility to contact your physicians to ensure all relevant medical records are forwarded to PSRS.

MEMBER INFORMATION		
Name - Last	First Name, MI	Account ID
Date of onset of current medical condition or injury:		
PRESENT CONDITION OF MEMBER		
Chief Complaints:		
Subjective symptoms:		
DIAGNOSIS		
Diagnosis 1:		
Objective Examination Findings 1:		
Diagnostic Test – Dates and Findings:		
Diagnosis 2:		
Objective Examination Findings 2:		
Diagnostic Test – Dates and Findings:		

Restrictions

What are the member's physical limitations and work restrictions?

Please address all below if applicable:	Max*	Not Applicable	Occasional 0 to 2.6 hours/day	Frequent 2.7 to 5.3 hours/day	Constant 5.4 to 8 hours/day
Low Lift (floor to knuckle)	☐	☐	☐	☐	☐
Mid Lift (knuckle to shoulder)	☐	☐	☐	☐	☐
Full Lift (floor to shoulder)	☐	☐	☐	☐	☐
Carrying	☐	☐	☐	☐	☐
Pushing	☐	☐	☐	☐	☐
Walking	N/A	☐	☐	☐	☐
Climbing	N/A	☐	☐	☐	☐
Balance	N/A	☐	☐	☐	☐
Stoop	N/A	☐	☐	☐	☐
Kneeling	N/A	☐	☐	☐	☐

Other Comments:

MEMBER INCAPACITY

Name - Last	First Name, MI	Account ID

To qualify for a disability retirement, the member must meet the legal standard under Missouri law which provides,

Disability, as a basis for retirement, shall render the individual incapable of earning a livelihood in any occupation and shall be of such a nature as to warrant the assumption that it will be permanent.

Based on the standard above, is the member disabled from working any job?

Yes ◯ No ◯

If so, please explain why.

Last date you have seen the claimant:

Do you anticipate improvement that will permit the member to return to employment? Yes ◯ No ◯

If so, please explain.

REQUIRED SIGNATURE

I certify that the information provided is correct to the best of my knowledge.

☐ *I have provided all necessary **medical records** to PSRS/PEERS.*

Physician's printed name	Type of practice/specialty	
Physician's signature	Date Signed	Telephone Number ( )
Address		
City	State	Zip Code