Teachers' Retirement System of the State of Kentucky

479 Versailles Road, Frankfort, KY 40601
800-618-1687

Physician's Disability Evaluation Report

To be completed by physician

Patient's/ TRS member's name (Last, first)	
Examination date (must be in last three months):	**TRS ID or Social Security number**

To the physician: This TRS member is applying for a retirement annuity due to disability. Depending on the member's situation, the law has different requirements to be eligible for disability retirement, so answers to questions two and three are needed. Attach reports, statements and other information regarding examinations that have been performed in relation to the patient's disabling physical or mental condition. Please print legibly. Your promptness in returning this completed form (**all sections**) will assist in evaluating this member's eligibility for disability benefits. Incomplete forms will be returned.

1. History of disabling condition and symptoms.

2. Is the disability the result of a single traumatic duty-related event, and does it leave the member totally and permanently disabled to engage in any occupation for remuneration or profit as a result? ☐ Yes ☐ No

3. Is the disability total and permanent and does it prevent the performance of the member's job duties for a period of at least 12 months? ☐ Yes ☐ No

4. Physical examination by physician

Age:	Weight:	Height:	Blood pressure:

General condition (mental or physical that pertain to disability)

Laboratory tests and results

Continued on back

Patient's/ TRS member's name (Last, first)	TRS ID or Social Security number

5. Diagnosis

6. Describe how the disabling condition(s) affect the member's ability to perform job duties. Include what tasks the member would be or is unable to perform and restrictions the member would have or has with regard to the specific job.

7. What *specific* steps have been taken to correct the disabling condition(s)? (Examples: surgery, therapy, medications, counseling)

8. With the proposed corrective measures, would you expect this patient/member to be able to return to work?

☐ Yes ☐ No	**Explain**:

9. In your opinion, would this member benefit from a rehabilitation program?

☐ Yes ☐ No	**Explain**:

Physician's Conclusion	I certify this member is physically and or mentally (check one) ☐ **disabled** ☐ **not disabled.**

Physician's signature		Date
Physician's name (print)	**Type of specialist (if applicable)**	
Address (City, state, ZIP)		**Phone**

Upon completion, return to:
TRS
479 Versailles Road
Frankfort, KY 40601