

## Report of Physician

<b>PATIENT'S Last Name</b>	<b>First Name</b>	<b>Social Security Number/KTRS ID#</b>

### Report of Physician

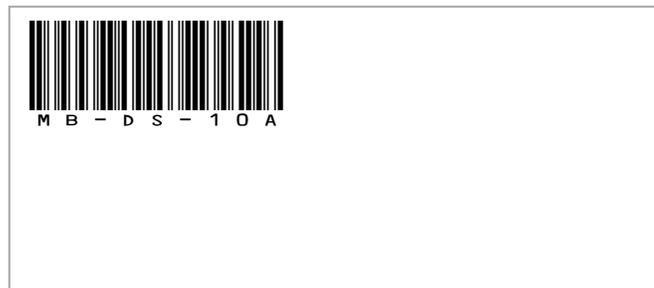
To the Physician: This member is applying for a retirement annuity due to total and permanent disability which prevents the performance of his/her job duties for a period of at least twelve (12) months. Please attach reports, statements, and other information regarding examinations that have been performed in the last three (3) years period indicating the patient's physical or mental condition. We also request that you print legibly to eliminate any possible confusion.

NOTE: Your promptness in completing this form will assist us greatly in evaluating this member's eligibility for disability benefits.

### All Sections MUST Be Completed

**NOTE: THIS EXAMINATION MUST HAVE TAKEN PLACE WITHIN THE PAST THREE MONTHS.**

<b>1. History of disability &amp; symptoms.</b>				
<b>2. Physical Examination by Physician</b>	<b>Age</b>	<b>Weight</b>	<b>Height</b>	<b>Blood Pressure</b>
	<b>General Condition (mental or physical that pertain to disability)</b>			
	<b>Laboratory Tests and Results</b>			



<b>3. Diagnosis</b>

*Continued ...*

4. Please discuss how the disabling condition(s) would have an effect on the member's job duties.	<i>This should include such information as what tasks the member would be unable to perform and the restrictions they would have with regard to their specific job.)</i>		
5. Corrective Measures	<i>What SPECIFIC steps have been taken to correct the medical problem? (ie: surgery, therapy, medicines, counseling)</i>		
6. Conclusion & Prognosis	A. With the proposed corrective measures, would you expect this patient to be able to return to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Please explain:</i>
	B. In your opinion, would this member benefit from a rehabilitation program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Please explain:</i>

**YOU MUST PROVIDE ALL THE INFORMATION REQUESTED BELOW OR THIS FORM WILL BE RETURNED.**

<b>Recommendation by Physician</b>	I certify that this applicant <input type="checkbox"/> IS DISABLED or <input type="checkbox"/> IS NOT DISABLED physically and/or mentally to perform his/her job duties.
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**KRS 161.661(10) states that a member retired by reason of disability shall be required to undergo periodic examinations at the discretion of the board of trustees to determine whether the disability allowance shall be continued. When examination and recommendation of a medical review committee indicate the disability no longer exists, the allowance shall be discontinued.**

**Upon completion, please return to:**  
KTRS | Attn: Disability Dept. | 479  
Versailles Road | Frankfort, KY 40601

<b>Signature of Physician</b>	<b>Date</b>
<b>Printed Physician's Name</b>	<b>Type of Specialist</b>
<b>Address</b>	<b>Phone Number</b>
<b>City, State, Zip Code</b>	