Municipal Employees' Retirement System of Michigan
1134 Municipal Way • Lansing, MI 48917
800.767.2308 • Fax: 517.703.9706
www.mersofmich.com

Physician's Statement of Disability

Retain a copy for your records

One of the requirements of the MERS plan document is that, in order to receive disability retirement benefits, participants must be unable to perform the duties required for continued employment by their municipality or court. This form is to be completed by the physician and returned to the employee for submission to MERS. Receipt of retirement benefits by the employee may be dependent upon completion of statements by two physicians. Please **PRINT** or **TYPE**.

Completed by ☐ Personal physician ☐ Physician for municipality ☐ Other treating physician

1. Patient information

Patient's name (Last, First Middle)*	Height	Weight	Last 4 of SSN

2. Diagnosis Details

Disabling diagnosis (and ICD-9/10 Code) Please explain fully. Provide additional pages, if necessary.

Please attach a copy of any medical reports or test results related to the disabling diagnosis.

Date of onset of disabling illness/injury (mm/dd/yyyy):

Date patient first consulted YOU for this disabling illness/injury (mm/dd/yyyy):

Date of last office visit for the disabling illness/injury (mm/dd/yyyy):

Date patient first consulted ANY physician for this illness/injury (mm/dd/yyyy):

Name of physician

Physician's mailing address	Physician's City	Physician's State	Physician's Zip

Date symptoms first appeared (mm/dd/yyyy):

Describe hospitalization or treatment provided for the disabling condition. (Provide additional pages if necessary.)

Describe hospitalization and/or surgical intervention (1st instance):

From (mm/dd/yyyy): to (mm/dd/yyyy):

Name, address of hospital or treatment provider

Describe hospitalization and/or surgical intervention (2nd instance, if applicable):

From (mm/dd/yyyy): to (mm/dd/yyyy):

Name, address of hospital or treatment provider

Describe hospitalization and/or surgical intervention (3rd instance, if applicable):

From (mm/dd/yyyy): to (mm/dd/yyyy):

Name, address of hospital or treatment provider

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What other reasonable treatment has NOT been attempted/completed? (Provide additional pages if necessary.)

Describe laboratory and diagnostic tests relevant to the disabling condition. (Provide additional pages if necessary.)

Identify patient's medications (past and present) relevant to the disabling condition. (Provide additional pages if necessary.)

In an 8-hr work day, patient can (check full capacity for each activity):

Total hours at one time:	Sit	0	1	2	3	4	5	6	7	8	(hours)
	Stand	0	1	2	3	4	5	6	7	8	(hours)
	Walk	0	1	2	3	4	5	6	7	8	(hours)
Total during entire 8-hr work day:	Sit	0	1	2	3	4	5	6	7	8	(hours)
	Stand	0	1	2	3	4	5	6	7	8	(hours)
	Walk	0	1	2	3	4	5	6	7	8	(hours)

Patient can lift:

	Never	Occasionally	Frequently	Constantly
Up to 5 lbs				
6–10 lbs				
11–20 lbs				
21–25 lbs				
26–50 lbs				
51+ lbs				

Patient can carry:

	Never	Occasionally	Frequently	Constantly
Up to 5 lbs				
6–10 lbs				
11–20 lbs				
21–25 lbs				
26–50 lbs				
51+ lbs				

Patient can use hands for repetitive action such as:

	Simple Grasping	Fine Manipulation
Right	☐ Yes ☐ No	☐ Yes ☐ No
Left	☐ Yes ☐ No	☐ Yes ☐ No

	Pushing and Pulling
Right	☐ Yes ☐ No (If yes, maximum pound capacity _____lbs)
Left	☐ Yes ☐ No (If yes, maximum pound capacity _____lbs)

Patient can use feet for repetitive movements as in operating foot controls:

Right	Left	Both
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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Patient is able to perform the following movements or actions:

	Never	Occasionally	Frequently	Constantly
Bend				
Squat				
Crawl				
Climb				
Reach above shoulder level				
Kneel				
Handle objects				
Fingering				
Feeling				

Restriction of activities involving:

	No Restriction	Mild Restriction	Moderate Restriction	Total Restriction
Unprotected heights				
Being around moving machinery				
Exposure to marked changes in temparature and/or humidity				
Driving automotive Equipment				
Exposure to dust, fumes, or gases				

Remarks on above or other functional limitations:

Has the patient become incapacitated for continued employment by his/her employing municipality or court? ❒ Yes ❒ No

(Please explain.)

Can the patient perform his/her current job with restrictions or do other comparable work? ❒ Yes ❒ No

(Please explain.)

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The patient's incapacity is expected to be:

- ☐ Temporary – What is the expected date the patient could return to their position? (mm/dd/yyyy) _____
- ☐ Permanent
- ☐ Progressive: ☐ Rapidly progressive ☐ Slowly progressive

Please explain:

The patient's performance of work-related duties:

- ☐ Was the sole cause of the disabling injury/illness
- ☐ Aggravated a pre-existing or non-work related condition that resulted in the disability
- ☐ Did not cause or aggravate the injury/illness underlying the disability (the patient's disability is non-work related)

Please explain:

Does the patient require any medication, treatment, or rehabilitation as a result of the disability? ☐ Yes ☐ No

Please explain:

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Prognosis for recovery from disabling injury/illness (attach additional pages if necessary):

3. Physician's signature

Signature of physician*	Date (mm/dd/yyyy)*	Specialty*

Physician's name (print or type)	Board certified?*
❒ MD ❒ DO	❒ Yes ❒ No

Physician's mailing address*	Telephone number (with area code)*

Physician's city*	State*	Zip*	Fax number (with area code)*

Data collected on this form will be used by MERS staff for identification and documentation only.

* Required field

You can submit this form online!

If you already have a myMERS account, you can upload this form online. Look for the **File Upload** feature to easily and securely submit completed forms.

You may also mail completed form to:

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