



U.S. Department of State
Foreign Service Retirement Systems
PHYSICIAN'S STATEMENT
In Connection With Disability Retirement

PART A - TO BE COMPLETED BY APPLICANT

INSTRUCTIONS		
Complete Part A and give this form to your physician. He or she is to complete Part B and mail it to the address in Item 4, Part A.		
1. Print or Type Full Name <i>(Last, First MI)</i>		2. Date of Birth <i>(mm-dd-yyyy)</i>
3. I hereby give my permission for your release to the U.S. Department of State of any or all information or records connected with my illness		
Signature	Address <i>(Including ZIP Code)</i>	Date <i>(mm-dd-yyyy)</i>
4. ADDRESS TO WHICH PHYSICIAN SENDS STATEMENT	U.S. Department of State Medical Director (M/DGHR/MED) SA-1 Room 209 Washington, DC 20522-0108	

PART B - TO BE COMPLETED BY PRIVATE PHYSICIAN

INSTRUCTIONS
1. Report in detail the clinical symptoms and findings upon which your diagnosis and conclusions are based. A complete and objective report may permit a decision on the claim for disability without need for further examination and inconvenience to the applicant.
2. Send the completed form to the office named by the applicant in Item 4, Part A.
3. Please enclose your report in a sealed inner envelope marked with the name of the applicant and the words "Disability Retirement-Privileged-Medical Information."

MEDICAL HISTORY

1. How long has employee been under your professional care for the indicated disability? <i>(Give dates)</i>	2. When did you last see the employee for examination or treatment? <i>(Give dates)</i>	
3. If employee is currently hospitalized or has been hospitalized recently, please furnish		
Name and Address <i>(Including ZIP Code)</i> of hospital or other medical facility	Date of Admission <i>(mm-dd-yyyy)</i>	Date of Discharge <i>(mm-dd-yyyy)</i>
Please attach summary report of hospitalization or abstract of hospital records		
4. Describe fully the onset of disability, progression, and current symptoms		

PHYSICIAN PLEASE COMPLETE OTHER SIDE OF THIS STATEMENT ALSO

DIAGNOSIS

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CONCLUSIONS

NOTE: Under the Foreign Service Retirement Systems the term disability means disabled for useful and efficient service by reason of disease or injury not due to vicious habits, intemperance, or willful misconduct.

1. Date (mm-dd-yyyy) disability began?	2. How long is disability expected to last?	3. Is disability due to vicious habits, intemperance, or willful misconduct? <input type="checkbox"/> Yes <input type="checkbox"/> No
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PHYSICIANS'S NAME AND ADDRESS

1. Type or Print Physician's name	2. Physician's Signature
3. Physician's Address (Including ZIP Code)	4. Date (mm-dd-yyyy)