

Member's List of Disability Information



Teachers
Retirement
System of
Georgia

This form must be filled out if you are applying for Disability Retirement.

Please provide TRS with the physicians (including specialists), psychologists, psychiatrists, hospitals and/or clinics you have seen in the last 12 months from whom you are requesting medical information relating to your disability.

Be sure to provide complete information for each provider. Please send this form with your Application for Disability Retirement form to TRS. If you need additional space, please use the back of this page.

▼ To Be Completed by Member -- please print clearly

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Social Security Number

Date of Birth

Last Name

First Name

Middle Initial

Street Address or P.O. Box

()
Telephone Number (daytime)

City

State

Zip Code

Name of Provider

()
Phone Number

Address (street, city, state, zip code)

Date Last Seen

Date of Next Appointment

Reason for Treatment

Name of Provider

()
Phone Number

Address (street, city, state, zip code)

Date Last Seen

Date of Next Appointment

Reason for Treatment

Name of Provider

()
Phone Number

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M E D I C A L