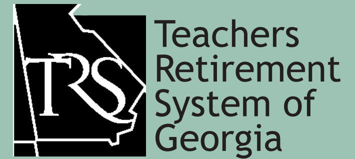
Physician's Report



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

As a member of the Teachers Retirement System of Georgia (TRS), it is your responsibility to obtain the necessary medical information from all treating sources needed to determine the status of your disability retirement request. Any charges for this information will be at your expense. In some cases, TRS may require an evaluation by an independent physician of our choice. If this is necessary, you will be notified and TRS will assume the responsibility for that cost only.

You need to send one of these reports to each physican from whom you have received treatment/diagnosis for your medical condition(s) in the last 12 months. Please attach a copy of your current job description to each report. Job descriptions are available from your personnel department.

TRS guarantees the confidentiality of the information provided on this form.

▼ To Be Completed by Member -- *please print clearly*

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 Physician: ____________________ Physician's Phone Number: (_____)__________

Address of Physician: ____________________

City: ____________________ State: ______ Zip Code: __________

Authorization for Release of Medical Information

This is my written authorization to release to the Teachers Retirement System of Georgia any and all medical records and information for the purpose of processing my disability retirement application. This includes any psychiatric/psychological records.

Signature: ____________________ Date: ____________________

After completing this section, please forward this report to your physican. If you have been treated/diagnosed by more than one physician in the last 12 months, you must send a copy of this report to each one. Do not forget to attach a copy of your job description to each report

▼ To Be Completed by Physican -- *please print clearly*

Please document diseases, diagnoses and current condition(s). Please include copies of test results, notes from office visits, blood tests, and x-ray reports for the past 12 months. Be sure to include any records that prove the medical diagnosis.

This person has applied for disability retirement with the Teachers Retirement System of Georgia and you have been named as a treating physician. Your information is vital in determining disability status for the job currently held. A job description is attached for your review. TRS needs a current evaluation. Please state specifically whether or not you determine that this person is disabled for the current job held. The person has signed above authorizing the release of all medical information.

Please bill the person named above for any charges relating to this request. Thank you for your cooperation.

Ability to Perform Job

For the currently held position, and according to the job description attached, I find that this person is:

Able to perform the job as described. ❑**Yes** ❑**No**

Two Northside 75 ● Suite 100 ● Atlanta, GA 30318 ● (404) 352-6500 ● (800) 352-0650 ● fax (404) 352-4885 ● www.trsga.com

Physician's Report cont.

▼ To Be Completed by Physician -- *please print clearly*

Job Duties
Please state the job duties that the person cannot perform.

Disability Diagnosis
Please state the diagnosis for the cause of the disability.

Physical Findings & Test Results
Please state the specific physical findings and test results confirming this diagnosis.

Please send copies of these test results. If cancer is involved, attach copies of the confirming pathology reports. If AIDS is involved, attach copies of HIV and CD4 test reports. If you do not have copies of these reports, please tell us where they can be obtained.

Abnormalities
Please state the specific abnormalities disabling this patient.

Recovery
Using the attached job description, can this patient be expected to recover sufficiently to return to the described job?

❑Yes ❑No If yes, please state an approximate time.

Treatment
Please state the treatment you have recommended.

Has the patient followed through with the recommended treatment?

State dates and results of treatment.

Referrals
If you have referred this patient to any specialists, please list them.

Name	Specialty	Address	Date of Referral

Other Information
Please provide any other information that you think will assist in the determination of this patient's claim for disability. If more space is needed, please explain on a separate page and attach to this report.

Physician's Authorization
By signing, you certify that the information provided above is accurate.

Confidentiality will be maintained.

Signature of Physician

Physician's Name Printed

Patient's Last Name, First Name

Date

After completing this report, please forward it, along with any attachments, directly to TRS. We appreciate your assistance.

Two Northside 75 ● Suite 100 ● Atlanta, GA 30318 ● (404) 352-6500 ● (800) 352-0650 ● fax (404) 352-4885 ● www.trsga.com