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| {SFNLogo} | **54399-****{stdMbrPERSLinkID}** |
| **DISABILITY RETIREMENT ATTENDING PHYSICIAN’S STATEMENT OF DISABILITY** |
| NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM |
| SFN 54399 (Rev. 09-2021)  **{SFNAddress}** |

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| Under the Disability Retirement Disability Plan, an employee is eligible to receive benefits if medically disabled from performing the duties of any occupation the employee may be qualified for based on individual training, education, experience, and past job history. | | | | | | | | | | | | | |
| The patient is responsible for the completion of this form without expense to the employer. | | | | | | | | | | | | | |
| **PART A PARTICIPANT IDENTIFICATION** | | | | | | | | | | | | | |
| Name (Last, First, Middle) {stdMbrFullNameLFM} | | | | | | | NDPERS Member ID {stdMbrPERSLinkID} | | | | | | |
| Last Four Digits of Social Security Number {stdMbrLastFourDigitsOfSSN} | | | | | | | Date of Birth (mm/dd/yyyy) {stdMbrDateOfBirth} | | | | | | |
| PART B PHYSICIAN’S STATEMENT | | | | | | | | | | | | | |
| In order to determine benefit eligibility and rehabilitation, answer the following questions. | | | | | | | | | | | | | |
| HISTORY | | | | | | | | | | | | | |
| Date symptoms first appeared or accident happened? | | | Date patient ceased work because of disability | | | | | | | Has patient ever had same or similar condition?  Yes No | | | |
| PRESENT CONDITION | | | | | | | | | | | | | |
| Subjective Symptoms | | | | | | Objective Findings | | | | | | | |
| Diagnosis | | | | | | Prognosis | | | | | | | |
| TREATMENT | | | | | | | | | | | | | |
| Date of First Visit / / | Date of Last Visit / / | | | Frequency of Visits | | | | | | | Date Patient was Last Examined / / | | |
| EXTENT OF DISABILITY | | | | | | | | | | | | | |
| 1. Is the employee totally disabled from any occupation as defined above? No Yes | | | | | | | | | | | | | |
| 2. If the disability is not considered total and permanent, do you anticipate a release to their regular occupation? No Yes- When? | | | | | | | | | | | | | |
| 3. If you answered “no”, do you anticipate a release to a less physically and/or emotionally demanding occupation? No Yes-When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If yes, please complete the physical capacities evaluation on the back side of this form, this will provide us with the physical limitations placed on the employee. | | | | | | | | | | | | | |
| 4. If the employee is totally disabled as defined above, would you feel it appropriate to consider VOCATIONAL and/or MEDICAL REHABILITATION? No Yes If yes, please complete the physical capacities evaluation on the back side of this form, this will provide us with the physical limitations placed on the employee. | | | | | | | | | | | | | |
| MENTAL CONDITION | | | | | | | | | | | | | |
| 1. Is the patient competent to endorse checks and direct the use of the proceeds thereof? No Yes | | | | | | | | | | | | | |
| Complete the appropriate section below if disability is due to CARDIAC CONDITION or VISUAL IMPAIRMENT. | | | | | | | | | | | | | |
| CARDIAC | | | | | | | | | | | | | |
| Functional Capacity (American Heart Association):Class 1 (No limitation) Class 3 (Marked limitation)Class 2 (Slight limitation) Class 4 (Complete limitation) | | | | | | | | | Blood Pressure | | | | |
| VISUAL IMPAIRMENT | | | | | | | | | | | | | |
| What was vision at last observation? | |  | | | O.D. | | | O.S. | Month | | | Day | Year |
| With Glasses | | |  | | |  |  | | |  |  |
| Without Glasses | | |  | | |  |  | | |  |  |

**(Continued)**

DISABILITY RETIREMENT ATTENDING PHYSICIAN’S STATEMENT OF DISABILITY

SFN 54399 (Rev. 09-2021) Page 2

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| PART C PHYSICAL CAPACITIES EVALUATION | | | | | | | | | | | | | | | | | | | |
| IMPORTANT: Please complete the following items based on your clinical evaluation, other testing results, patient discussions, and/or job analysis. Any item that you do not believe you can answer should be marked N/A (not available). | | | | | | | | | | | | | | | | | | | |
| In an eight hour workday, claimant can: (Check time for each activity) | | | | | | | | | | | | | | | | | | | |
|  | 1 hour | | 2 hours | | 3 hours | | | 4 hours | | 5 hours | | 6 hours | | | | 7 hours | | | 8 hours |
| Sit |  | |  | |  | | |  | |  | |  | | | |  | | |  |
| Stand |  | |  | |  | | |  | |  | |  | | | |  | | |  |
| Walk |  | |  | |  | | |  | |  | |  | | | |  | | |  |
| If any of the above three require alternating positions, please indicate frequency | | | | | | | | | | | | | | | | | | | |
| In terms of an eight hour workday, “occasionally” equals 0-33; “frequently” equals 34-36, “continuously” equals 67-100 percent. | | | | | | | | | | | | | | | | | | | |
| Claimant can lift… Never Occasionally Frequently Continuously  Up to 10 pounds  11-20 pounds  21-50 pounds  51-100 pounds | | | | | | | | | | | | | | | | | | | |
| Claimant can carry… Never Occasionally Frequently Continuously  Up to 10 pounds  11-20 pounds  21-50 pounds  51-100 pounds | | | | | | | | | | | | | | | | | | | |
| Claimant can use hands for repetitive action such as | | | | | | | | | | | | | | | | | | | |
|  | | Simple Grasping | | | | | Pushing and Pulling | | | | | | | Fine Manipulation | | | | | |
| Right | | Yes | | No | | | Yes | | | | No | | | Yes | | | | No | |
| Left | | Yes | | No | | | Yes | | | | No | | | Yes | | | | No | |
| Claimant can use feet for repetitive movements as in operating foot control | | | | | | | | | | | | | | | | | | | |
| Right | | | | | | Yes | | | | | | | No | | | | | | |
| Left | | | | | | Yes | | | | | | | No | | | | | | |
| Both | | | | | | Yes | | | | | | | No | | | | | | |
| Claimant is able to: Not at all Occasionally Frequently Continuously  Bend  Squat  Crawl  Reach above shoulder level | | | | | | | | | | | | | | | | | | | |
| Restrictions of activities: None Mild Moderate Total  Unprotected heights  Being around marked changes in temperature and humidity  Driving automobile equipment  Exposure to dust, fumes, and gases | | | | | | | | | | | | | | | | | | | |
| Remarks on Above, or other Functional Limitations | | | | | | | | | | | | | | | | | | | |
| **PART D CERTIFICATION** | | | | | | | | | | | | | | | | | | | |
| Name (print) | | | | | | | | | Degree | | | | | | Daytime Telephone Number | | | | |
| Mailing Address (print) | | | | | | | | | City (print) | | | | | | State | | ZIP Code | | |
| Signature of Attending Physician (Electronic Signature will not be accepted) | | | | | | | | | | | | | | | Date | | | | |