Physician's Report on Disability of Member

INSTRUCTIONS: The member of the Fairfax County Retirement System who is identified in items 1 through 6 of this form has applied for disability retirement under the Ordinance governing the Retirement Systems. In order that the Board of Trustees may make a decision in this case, information about his/her disability is needed. The member has filed a statement with the Board of Trustees authorizing his/her physician or physicians to report on his/her disability to the Medical Examining Board and the Board of Trustees of the Fairfax County Employees', Police Officer or Uniformed Retirement System.

The member's physician should complete items 7-13, and may make additional comments as necessary. **Please return this form along with a copy of a recent (within the past year) medical examination related to the reason for disability retirement** directly to the Retirement Systems.

1. Last name **First name** **Middle Name**	**2. Date of Birth**	**3. Social Security Number**
4. Present Address	**5. Date When Disability Began**	**6. Was disability incurred in performance of duties ?**

7. Diagnosis (primary diagnosis for the disability) and any other illness, disease, infirmity and/or complications resulting from that primary diagnosis which affects disability (please include the appropriate ICD codes and definitions).

8. Severity and extent of disability

9. Physical limitations (related to physical requirements of the job) **as a result of illness or infirmity**

10. Nature of treatment

11. Results of pathology reports and special studies (if applicable)

12. Prognosis and additional comments

13. Physician's Statement. The individual named in item 1 has been under my professional care from __________________ to _________________. In my opinion, he/she ☐ is ☐ is not totally incapacitated to perform the duties of the position stated on the Application for Disability Retirement. He/she ☐ is likely ☐ is not likely to remain incapacitated permanently. Therefore, he/she ☐ should ☐ should not be retired.

_______________________________ **Signature of Physician**

_______________________________ **Telephone Number**

_______________________________ **Date**

_______________________________ **Printed Name of Physician**

_______________________________ **FAX**

_______________________________ **Physician's Complete Mailing Address**

Fairfax County Retirement Systems
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