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- State Employees' Retirement System of Illinois
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2101 South Veterans Parkway, P.O. Box 19255, Springfield, IL 62794-9255

**NONOCCUPATIONAL DISABILITY MEDICAL REPORT**

Dear Doctor:

The employee named below has made application for disability benefits from the State Employees' Retirement System. Please complete and return this form to the above address. **THE EMPLOYEE'S ELIGIBILITY FOR BENEFITS CANNOT BE DETERMINED UNTIL WE RECEIVE THIS INFORMATION.** This form is acceptable only if completed by a licensed medical doctor.

Employee Name:	_____										
S.S.N.	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>										
Date of Birth	____/____/____										

DIAGNOSIS: \_\_\_\_\_

CURRENT SYMPTOMS: \_\_\_\_\_

PREGNANCY (LMP): \_\_\_\_\_ (EDC): \_\_\_\_\_

PLEASE LIST RESULTS OF APPROPRIATE DIAGNOSTIC STUDIES: \_\_\_\_\_

NATURE OF TREATMENT AND DATES: (Enclose your statement if more convenient) \_\_\_\_\_

ONSET DATE OF DISABILITY \_\_\_\_\_ IS PATIENT STILL UNDER YOUR CARE? ☐ YES ☐ NO

IF PATIENT HAS BEEN RELEASED TO RETURN TO WORK: \_\_\_\_\_  
(Please enter date released)

REMARKS: \_\_\_\_\_

THE ABOVE NAMED INDIVIDUAL APPEARED BEFORE ME FOR MEDICAL EXAMINATION.  
THE DIAGNOSIS, TREATMENT AND REMARKS ARE MY PROFESSIONAL OPINION.

PRINTED NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE: \_\_\_\_\_

REGISTRATION NUMBER: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

# Fers Disability Medical Report Document

**Peter B. Broida**

A red circular graphic with a gradient, appearing as a partial circle or a thick arc, located to the right of the name bar.

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