LSERS
LOUISIANA SCHOOL EMPLOYEES' RETIREMENT SYSTEM

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14-12C
Form 12C
6/17

Print Reset

Physician Report of Disability

This form must be completed by the applicant and their physician as part of the process for Disability Retirement, Annual Re-Examination, or to certify a Surviving Child with a total physical or intellectual disability. Legible copies of all pertinent medical records must be attached; including, but not limited to laboratory and other diagnostic test results, FCE results, hospitalizations and operative procedure summaries. If psychiatric, attach complete psychiatric evaluation.

Section 1 - Reason for Completion

Check one: ☐ Disability Retirement ☐ Annual Re-Examination ☐ Surviving Child with Disability

Section 2 - Patient Information/Medical Records Release Authorization

Last Name	First Name	MI	Suffix	Social Security Number

Address (Street/P. O. Box)	Telephone Number ☐ Home ☐ Cell
City, State, and Zip Code	Email Address

I hereby authorize release of all relevant medical information and records directly to the Louisiana School Employees' Retirement System. I understand I am responsible for all costs associated with any medical examination.

Patient's Signature (Do not print or type)	Date Signed (MM/DD/YYYY)

Section 3 - Physician Report of Disability

Instructions: Objective clinical findings and laboratory evidence must be sufficient to justify either this patient's claim of inability to perform their job duties outlined in their official job description, or their complete dependence upon another for their care and daily living for the purpose of validating survivor benefits. Should you choose to dictate your medical report, please include the information outlined below:

This patient has been under my professional care since:	/	/	Enter as MM/DD/YYYY
Most recent examination was done on:	/	/	Enter as MM/DD/YYYY

History of present injuries, condition of diseases, psychiatric (if applicable), dates, symptoms, etc.:

Social and biographical history:

Physical examination:

Vital Signs: Height ____ ft. ____ in. Weight _____ lbs. Pulse Rate _____

Blood Pressure: _____ / _____ Arm: _____

Member Name _____ Social Security Number _____

Section 3 - Physician Report of Disability - continued

Neuropsychiatric examination:

Places and dates of all psychiatric hospitalizations (if applicable)

Treatment and response:

Prognosis (for psychiatric, please include mental status and date last seen):

Primary Diagnosis		Secondary Diagnosis			
ICD10 Code	ICD10 Code Description	ICD10 Code	ICD10 Code Description	ICD10 Code	ICD10 Code Description

Have you referred this patient to another physician? If yes, please provide physician information below: ☐ Yes ☐ No

Name of Physician

Address (Street/P. O. Box)

City, State, and Zip Code

Section 4 - Medical Opinion - please mark all applicable boxes:

☐ The patient has a total and permanent disability and is unable to perform job duties outlined in their official job description.

☐ The patient is unable to return to employment as outlined in their official job description.

☐ The patient is dependent upon another for care and daily living.

Physician's Signature (Do not stamp, print, or type) | Date Signed (MM/DD/YYYY)

Physician's Printed Name | Area of Specialty | Telephone Number