



PHYSICIAN STATEMENT FOR DISABILITY RETIREMENT

Patient's Name _____

Dear Doctor:

This employee of Los Angeles County has applied for a disability retirement. The employee must present medical evidence from a physician pertaining to the disabling illness or injury in connection with the application. Your completed Physician Statement will be included in the package of information sent to the Board's panel physician.

Your evaluation should determine if the employee can perform the particular duties as outlined in the Los Angeles County Class Specification. The employee will provide you a copy of the Class Specification. **To be considered disabled under Retirement Law, the employee must be permanently disabled AND unable to perform a substantial portion of the tasks of his/her County job.**

Please do not attach an earlier narrative report in lieu of filling out this form. Please complete the attachments, **sign** the Physician Statement, and attach it to the Class Specification. Return them to the patient.

If you have any questions please call LACERA's Disability Retirement Division at 1-800-786-6464, Ext. 2419

Sincerely,

Gregg Rademacher

GREGG RADEMACHER
Chief Executive Officer



PLEASE TYPE OR PRINT IN INK

Patient's Name _____

1. The patient is (**check one**):
 permanently and substantially incapacitated
 temporarily incapacitated
for a substantial portion of the duties as _____
_____ as outlined in the attached Los Angeles County Class Specification.

2. What is your diagnosis(es)? _____

3. What objective findings support your diagnosis(es)? _____

4. What are the symptoms related to this illness/injury? _____

5. When and how did the symptoms first appear? _____





Patient's Name _____

6. What functions of the job can the patient NOT PERFORM? Why? (Please be specific.) _____

7. Will the patient's condition improve enough to return to work? (Please explain your answer in detail.) _____

8. I am the patient's:
 treating physician examining physician

I hereby certify that the Physician's Statement is based on my examination and the attached Class Specification of the patient's duties.

Signature _____ Date _____

Name (print) _____

Address _____

Licensed to practice medicine under Laws of the State of California as Doctor of

Specialty _____

NOTE: This form must be **signed** by the physician in order to be valid.

(A stamped signature will not be accepted.)