

SUPPLEMENTAL RETIREMENT PLAN
MEDICAL EXAMINATION REPORT

Participant Name _____ Participant SS# OR UID# _____ Participant Date of Birth _____

Participant Address _____
Number Street City State Zip Code

ALL OF THE FOLLOWING INFORMATION MUST BE COMPLETED BY THE PHYSICIAN

DIAGNOSIS INCLUDING SUBJECTIVE SYMPTOMS, OBJECTIVE CLINICAL FINDINGS, OBJECTIVE DIAGNOSTIC STUDIES AND RESULTS, COMPLICATIONS, AND THE BASIS FOR YOUR ULTIMATE FINDING OF TOTAL DISABILITY (CONTINUE ON BOTTOM OF REVERSE SIDE IF MORE SPACE IS NEEDED)

ICD diagnostic code(s): _____

The above named individual was most recently examined on _____. (MONTH/DAY/YEAR)

This disability **originally** commenced on or about: _____. (MONTH/DAY/YEAR)

The **current period** of disability commenced on or about: _____. (MONTH/DAY/YEAR)

Medical treatment (is) _____ (is not) _____ required at the present time.

Re-examination is recommended on or about _____.

IMPORTANT -- PHYSICIAN MUST INITIAL WHICHEVER APPLIES

I hereby certify that:

_____ I am of the opinion that this individual is unable to engage in any substantial gainful activity due to a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

_____ I am of the opinion that this individual is able to engage in substantial gainful activity as follows:

Physician Printed Name _____ (must be LEGIBLE) Physician Signature _____ Date Completed by Physician _____

Address _____
Number Street City State Zip

Telephone _____ (Area Code) Number Physician Federal Tax I.D. # _____

Physician License # _____ License Issued by State of _____