



**Tennessee Consolidated Retirement System**  
502 Deaderick Street  
Nashville, Tennessee 37243-0201

**Attending Physician's Report of Disability\***

**\*Attention applicant and physician:**

- 1. This is an authorization requested by the applicant in order that discussion of any and all information concerning the applicant's disability may be freely given to the TCRS.**
- 2. The expense of furnishing this information must be paid by the applicant.**
- 3. In addition to the completion of this form, the physician is requested to attach all office notes, hospital summaries, test results and any other medical information available.**

<b>Part I - To be filled in and signed by applicant.</b>			
1. Applicant's Name: (last)		(first)	(middle)
2. Address: (street)		(city)	(state) (zip)
3. Applicant's Signature:		4. Social Security #:	
5. Name of Physician:	6. Address: (street) (city) (state) (zip)		

<b>Part II - To be completed by physician.</b>			
1a. Current Height:                      Feet                      Inches		1b. Current Weight:                      Pounds	
2. You were first consulted in present illness:		(month)	(day) (year)
		/	/
3a. You are now attending the applicant:		( ) Yes	( ) No
3b. If not, state why:			
<i>Diagnosis</i>			
4. Primary impairments:			
5. Secondary impairments:			
<b>Complete <i>only</i> the parts that are applicable. Give results or description.</b>			
<i>Musculoskeletal System</i>			
6. X-ray findings:			
7. Limitation of motion and the degree:			
8. Comment on history of pain, swelling and stiffness:			
<i>Respiratory System</i>			
9. Chest x-ray findings:			
10. Pulmonary function/arterial blood/gas studies:			
11. In the case of pulmonary tuberculosis, provide sputum culture results:			
12. Cyanosis/dyspnea:			

**Part II cont'd- To be completed by *physician*.**

*Cardiovascular System*

13. EKG's/enzyme studies:

14. Blood pressure readings:

15. Chest x-ray, including cardio-thoracic ratio:

16. Chest pain and medication used to relieve pain:

17. Edema, pigmentation, cyanosis or ulceration:

18. End-organ damage as a result of hypertension:

19. Indicate New York Heart Classification:

*Mental Disorders*

20. Impairment of memory, judgement/ability to perform calculations:

21. Reduction in daily activities, interests, personal habits and ability to relate to others:

22. Ability to relate to and communicate with supervisors and co-workers in a work situation: ( ) Yes ( ) No  
Explain:

*Hearing*

23. Results of audiological evaluation (with hearing aid):

*Visual*

24. Best corrected visual acuity and visual fields:

*Digestive*

25. Liver studies, x-ray findings, endoscopy/barium enema studies, weight loss:

*Genito-Urinary*

26. BUN/creatinine clearance, report of dialysis treatment:

*Hemic and Lymphatic*

27. Complete blood count:

*Endocrine*

28. Diabetes, evidence of neuropathy, acidosis, amputations/ophthalmological changes:

*Neurological*

29. EEG and describe motor limitations:

*Neoplasms*

30. Biopsy and operative reports, severity and extent of lesion:

*Prognosis*

31a. Based on your recommended treatment, give degree of improvement that can reasonably be anticipated along with approximate period of time required to achieve this improvement:

31b. The impairment has or is expected to last 12 continuous months: ( ) Yes ( ) No

32. The impairment prevents performance of past work: ( ) Yes ( ) No

33a. The impairment prevents engagement in all other gainful employment.: ( ) Yes ( ) No

33b. If not, indicate type of work the applicant is capable of performing:  
( ) Heavy ( ) Medium ( ) Light ( ) Sedentary

34. Include any hospitalization records, including discharge summary:

35. Signature:

36. Date: