NEWPORT NEWS EMPLOYEES RETIREMENT FUND
NEWPORT NEWS, VA

REPORT OF PHYSICIAN

Dear Doctor _____, you are authorized to fill out this form and forward same to Director of Finance, City of Newport News Employees' Retirement Fund.

Applicant Signature: _____ Date: _____
Social Security Number: _____ Department: _____
Address: _____
_____
Phone: _____

ABOVE TO BE EXECUTED AND SIGNED BY APPLICANT FOR DISABILITY RETIREMENT

TO THE PHYSICIAN RENDERING THE FOLLOWING REPORT:

It is important that you make a full report of the patient's illness and the details of your findings so that the Medical Board of the City of Newport News Employees' Retirement Fund, whose duty it is to review the report and render an opinion, will have a clear-cut picture of the patient's condition. Simply stating "Arthritis", "Heart Disease", "Nervous Trouble", etc., without going into the details of the patients complaints and object findings, the degree of disability and a reasonable comprehensive statement as to the prognosis and treatment, does not give sufficient information on which to adequately evaluate the report. Lack of sufficient medical evidence will result in the Medical Board not being able to promptly and properly determine the case of the above applicant for Disability Retirement.

Your complete cooperation will avoid delay and will be appreciated.

Please print or type the following information.

I hereby certify that _____ has been under my professional care since _____.

I. Please give a detailed history of medical condition(s) with specific references to onset and course of condition(s):

II. Results of last exam (Please include copies of all diagnostic testing as applicable to the patient).

A. Physical Exam:

B. Laboratory:

C. EKG:

D. Radiographic:

E. Mental Status and Psychological Testing (Results of Standardized Testing):

F. Other Diagnostic Procedures:

III. Assessment of Current Status: Give Detailed Diagnosis and Clinical Impression

IV. Prognosis and Plans for Future Treatment:

A. Rehabilitation:

B. Re-Evaluation:

C. Estimate of Partial or Full Recovery:

V. Explanation of Impact of Medical Condition on Life's Activities:

IMPACT OF MEDICAL CONDITION ON ACTIVITIES OF DAILY LIVING

A – Minimal
B – Slight
C – Moderate
D – Marked
E – Not Applicable

	A	B	C	D	E
Self-Care & Personal Hygiene (Urinating, Defecating, Brushing Teeth, Combing Hair, Bathing, Dressing Oneself, Eating)					
Communication (Writing, Typing, Seeing, Hearing, Speaking)					
Normal Living Postures (Sitting, Lying Down, Standing)					
Ambulation (Walking, Climbing Stairs)					
Travel (Driving, Riding, Flying)					
Nonspecialized Hand Activities (Grasping, Lifting, Tactile Discrimination)					
Sexual Function (Having Normal Sexual Function, Participating in Usual Sexual Activity)					
Sleep (Restful, Nocturnal Sleep Pattern)					
Social & Recreational Activities (Ability to Participate in Group Activities)					
Home Maintenance (Cooking, Cleaning, Child Rearing)					