TGRS
Tribal Government Retirement System

1134 Municipal Way, Lansing, MI 48917
Phone 877.641.8477 | fax 517.703.9706 | Web site: www.tgrsbenefits.org

PHYSICIAN'S STATEMENT

RETURN TO: Tribal Government Retirement System c/o TGRS-MERS
1134 Municipal Way
Lansing, MI 48917
Phone: (877) 641-8477 • Fax: (517) 703-9706

Completed by: ☐ Attending Physician ☐ Physician for Tribe ☐ Other Treating Physician

The MERS Plan Document provides for disability retirement benefits for a member who is totally incapacitated. This form is to be completed by the physician and returned to the employee. Receipt of retirement benefits by the employee may be dependent upon completion of statements by two physicians. (**PLEASE PRINT OR TYPE.** Page 4 provides additional space for supplemental information.)

1. Patient's Name (Last, First, Middle)		Height	Weight
Street Address	City	State	Zip Code

2. Diagnosis: (Please explain fully. Provide additional pages, if necessary)

3. Onset of illness or injury.	Date ⇨	Month	Day	Year
4. When did patient first consult you for this illness or injury?	Date ⇨	Month	Day	Year
5. When did patient first consult any physician for this illness or injury?	Date ⇨	Month	Day	Year

5a. Name of physician.

5b. Physician's street address	City	State	Zip Code

6. When did symptoms first appear?	Date ⇨	Month	Day	Year

7. What operation, hospitalization or treatment has been provided? (Provide additional pages, if necessary.)

7a. Describe operation or treatment provided. From:	Month	Day	Year	to:	Month	Day	Year
7a. Hospital name and address	Physician's name and address						
7b. Describe operation or treatment provided. From:	Month	Day	Year	to:	Month	Day	Year
7b. Hospital name and address	Physician's name and address						

7c. Describe operation or treatment provided. From:	Month	Day	Year	to:	Month	Day	Year

7c. Hospital name and address	Physician's name and address

8. In an 8-hour workday, patient can: (Circle full capacity for each activity.)

Total At One Time

A. Sit	0	1	2	3	4	5	6	7	8	(hrs.)
B. Stand	0	1	2	3	4	5	6	7	8	(hrs.)
C. Walk	0	1	2	3	4	5	6	7	8	(hrs.)

Total During Entire 8-Hour Day

A. Sit	0	1	2	3	4	5	6	7	8	(hrs.)
B. Stand	0	1	2	3	4	5	6	7	8	(hrs.)
C. Walk	0	1	2	3	4	5	6	7	8	(hrs.)

9. Patient can lift:

	NEVER	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
A. Up to 5 lbs.	☐	☐	☐	☐
B. 6 - 10 lbs.	☐	☐	☐	☐
C. 11 - 20 lbs.	☐	☐	☐	☐
D. 21 - 25 lbs.	☐	☐	☐	☐
E. 26 - 50 lbs.	☐	☐	☐	☐
F. 51 - 100 lbs.	☐	☐	☐	☐

10. Patient can carry:

	NEVER	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
A. Up to 5 lbs.	☐	☐	☐	☐
B. 6 - 10 lbs.	☐	☐	☐	☐
C. 11 - 20 lbs.	☐	☐	☐	☐
D. 21 - 25 lbs.	☐	☐	☐	☐
E. 26 - 50 lbs.	☐	☐	☐	☐
F. 51 - 100 lbs.	☐	☐	☐	☐

11. Patient can use hands for repetitive action such as:

	Simple Grasping	Pushing and Pulling	Fine Manipulation
A. Right	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
B. Left	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

12. Patient can use feet for repetitive movements as in operating foot controls:

Right	Left	Both
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

13. Patient is able to:

	NEVER	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
A. Bend	☐	☐	☐	☐
B. Squat	☐	☐	☐	☐
C. Crawl	☐	☐	☐	☐
D. Climb	☐	☐	☐	☐
E. Reach above shoulder level	☐	☐	☐	☐

14. Restriction of activities involving:

	NONE	MILD	MODERATE	TOTAL
A. Unprotected heights	☐	☐	☐	☐
B. Being around moving machinery	☐	☐	☐	☐
C. Exposure to marked changes in temperature & humidity	☐	☐	☐	☐
D. Driving automotive equipment	☐	☐	☐	☐
E. Exposure to dust, fumes and gases	☐	☐	☐	☐

Remarks on above or other functional limitations:

15. Attach a copy of the **findings** from medical reports, x-rays, laboratory tests related to the diagnosis.

16. Check appropriate terms of incapacity.

☐ Permanent incapacity ☐ Temporary incapacity ☐ Slowly progressive ☐ Rapidly progressive

17. Is the patient totally and permanently incapacitated for employment with the participating municipality?

☐ Yes ☐ No

18. Is the patient's condition such that the patient will be able to resume any part of his/her work or secure other comparable employment? ☐ Yes ☐ No

Explain:

19. Is the patient's disability related to his\her actual performance of duty or to non-duty causes; and if duty-related, did the performance of duty directly cause the injury or disease underlying the disability, or did it aggravate a pre-existing condition that resulted in the disability?

Explain:

20. Does the patient require, as a result of the incapacity, any medication, treatment or rehabilitation? ☐ Yes ☐ No

Explain:

21. Prognosis (please explain fully). Provide additional pages, if indicated.

Signature of attending physician	Date	Specialty
Physician's name (print or type)	Telephone No. ( )	Certified by (specify board)
Physician's address	Board eligible (specify board)	

STATEMENT OF APPLICANT:

I authorize any employer, insurance company, including any workers' compensation or disability carrier, health care organization, hospital, or physician to release to the TGRS-MERS all information with respect to myself which may have a bearing on my application for disability retirement.

Applicant's signature	Date

The remainder of this page is intentionally blank. The physician may use this space to supplement any information provided on page 1, 2, or 3. Please return form to patient for submission to TGRS-MERS.