Attending Physician's Statement

Employee and Retiree Service Center (ERSC)
MONTGOMERY COUNTY PUBLIC SCHOOLS
45 West Gude Drive, Suite 1200 • Rockville, Maryland 20850

MCPS Form 455-25
July 2016

INSTRUCTIONS: To be completed by the attending physician when an employee is applying for disability retirement. Complete this form, sign and return to the Employee and Retiree Service Center (ERSC). **You may fax form to 301-279-3642/301-279-3651 or e-mail an electronically signed Adobe PDF file to ERSC@mcpsmd.org.**

Name of Patient _____ SSN:____ ____ ____ ____
Last 4 digits

Address _____

Date of Birth: _____/_____/_____

1. HISTORY

Weight:_____ Height:_____

When did the symptoms first appear or accident happen? _____/_____/_____

When did patient cease work because of disability? _____/_____/_____

Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes" state when and describe

_____

_____

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

Names and address of other treating physicians: _____

_____

2. DIAGNOSIS (including any complications)

Date of last examination? _____/_____/_____ ICD-9 Code **(mandatory)** _____

Diagnosis (including any complication) _____

Subjective Symptoms_____

_____

Objective Findings (including current X-rays, EKG's, Laboratory Data and clinical findings)

_____

If disability is due to pregnancy what is the expected delivery date?_____

Other diseases or infirmity affecting present condition? _____

3. DATES OF TREATMENT

Date of the first visit _____/_____/_____

Date of the last visit _____/_____/_____

Frequency ☐ Weekly ☐ Monthly Others (Specify)_____

Is patient still under your care for this condition? ☐ Yes ☐ No If "No" indicate date service terminated _____/_____/_____

4. NATURE OF TREATMENT (including type and date of surgery and medications prescribed, if any)

_____

_____

_____

5. PROGRESS

Has patient ☐ Recovered ☐ Improved ☐ Stabilized ☐ Retrogressed
Is patient ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

If the patient is hospital confined, provide name and address of the hospital:

_____

Confined from:_____ through _____

CONTINUED

6. CARDIAC (If Applicable)

Functional capacity

Class 1—No Limitation ☐ Class 2—Slight Limitation ☐ Class 3—Marked Limitation ☐ Class 4—Complete Limitation ☐

Blood Pressure (last visit): Date _____/_____/_____ Systolic _____ Diastolic _____

7. RESTRICTIONS

What restrictions are placed on the patient? _____

_____

Are the restrictions permanent? _____

_____

8. PHYSICAL IMPAIRMENT (* as defined in Federal Dictionary of Occupational Titles).

☐ Class 1—No limitation of functional capacity; capable of heavy work.* No restrictions (0%–10%)
☐ Class 2—Medium manual activity* (15%–30%)
☐ Class 3—Slight limitation of functional capacity; capable of light work (35%–55%)
☐ Class 4—Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60%–70%)
☐ Class 5—Severe limitation of functional capacity; capable of minimal (sedentary*) activity (75%–100%)

Remarks _____

_____

9. MENTAL/NERVOUS IMPAIRMENT (If applicable)

Please define "stress" as it applies to the claimant: _____

_____

What stress and problems in interpersonal relations has claimant experienced on the job?

☐ Class 1—Patient is able to function under stress and engage in interpersonal relations (no limitations)
☐ Class 2—Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
☐ Class 3—Patient is able to function in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
☐ Class 4—Patient is unable to function in stress situations or engage in interpersonal relations (marked limitations)
☐ Class 5—Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks _____

_____

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? Yes ☐ No ☐

10. PROGNOSIS

What is the patient's prognosis? _____

_____

Has the employee reached maximum medical improvement? _____

_____

If not, when do you feel patient's maximum medical improvement will be reached? 3 months ☐ 6 months ☐ 1 Year ☐ Longer ☐

What is the estimated date of the patients return to work (if any): _____/_____/_____

Do you consider the patient to be a viable candidate for job retraining (Rehabilitation Services)? _____

_____

11. REMARKS

_____

_____

_____

_____ _____ _____ _____
Name (Attending Physician) Print *Degree* *Specialty* *Telephone*

_____ _____ _____ _____
Street Address *City or Town* *State or Province* *Zip code*

_____ _____
Signature *Date*