NYCERS USE ONLY **F606**

Physician's Report of Disability

To be returned to NYCERS with member's application for disability retirement

To NYCERS' Medical Board:

This is to certify that

First Name	M.I.	Last Name

an employee in the New York City Department of

is under my care for the following:

Diagnosis: (Clinical problem and duration)

If caused by an accident: (Type, Place and Date)

Date [MM/DD/YYYY] / /

When, if ever, may he or she return to the full duties of his or her title? Date [MM/DD/YYYY] / /

Objective evidence:
X-Rays, EKG (Photocopies), Laboratory Reports, Pertinent physical findings, Consultant Reports, Hospital Reports, Etc.

Subjective evidence:
Symptoms, Complaints, Etc.

Treatment and result:

Client Services 340 Jay Street Brooklyn, NY 11201 (347) 643-3000 **www.nycers.org** **Mailing Address** 335 Adams Street, Suite 2300 Brooklyn, NY 11201-3724

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Member Number | Last 4 Digits of SSN

Physician First Name | Physician Last Name | Title (MD, DO, DC etc.)

Address | Apt. Number

City | State | Zip Code

Signature of Physician | **Date**

Applicant's Authorization for Release of Information

Dear Doctor _____, you are hereby authorized by me to fill out this form for the information of the Medical Board of the New York City Employees' Retirement System.

Signature of Applicant | **Date**

First Name | M.I. | Last Name

in Care of (if applicable) | Full Social Security Number

Address | Apt. Number

City | State | Zip Code