



California State Teachers'  
Retirement System  
Disability Services – MS 43  
Post Office Box 15275  
Sacramento, CA 95851-0275  
916.229.3870 / Toll-Free: 1.800.228.5453 / TTY: 916.229.3541  
[www.calstrs.com](http://www.calstrs.com)

Social Security Number:  -            -	Name:            (Last)	(First)	(M/I)
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Dear Doctor:

Objective documentation of this patient's medical condition is necessary to determine the initial or continuing eligibility for disability benefits from the California State Teachers' Retirement System (CalSTRS). Please provide copies of your clinical notes, in addition to any specific items checked below. This report is essential to the disability evaluation process. An incomplete report or a delay in the receipt of this form or requested records, could result in financial hardship for this patient.

NOTE: ANY FEE INVOLVED WITH THE COMPLETION OF THIS REPORT IS THE RESPONSIBILITY OF THE PATIENT.

**PLEASE PROVIDE THE FOLLOWING DOCUMENTATION**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> History           | <input type="checkbox"/> Treadmill Exercise Test               | <input type="checkbox"/> Visual Acuity Tests  |
| <input type="checkbox"/> Clinical Notes    | <input type="checkbox"/> EKG Report                            | <input type="checkbox"/> Audiometric Tests    |
| <input type="checkbox"/> Office Notes      | <input type="checkbox"/> Angiogram Reports                     | <input type="checkbox"/> Vocational Workshop  |
| <input type="checkbox"/> Out-Pat. Notes    | <input type="checkbox"/> EMG Reports                           | <input type="checkbox"/> Consultative Reports |
| <input type="checkbox"/> Physical Exam     | <input type="checkbox"/> EEG Reports                           | <input type="checkbox"/> Laboratory Reports   |
| <input type="checkbox"/> Surgery Reports   | <input type="checkbox"/> Pulmonary Function Tests              |   |
| <input type="checkbox"/> Path. Reports     | <input type="checkbox"/> Mental Status/Psychiatric Evaluations |   |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Psychological Tests                   |   |
| <input type="checkbox"/> X-Ray Reports     | <input type="checkbox"/> Complete Special Form Enclosed        |   |

Please indicate the items checked above that are not available:

NAME:

SSN:

Please complete this report and promptly and return it to CalSTRS at the address on the bottom of page 1.

PLEASE TYPE OR PRINT LEGIBLY IN BLACK INK

Date of most recent examination: (Mo./Day/Yr.)	Date this patient became unable to work: (Mo./Day/Yr.)
Date this patient first came under your care: (Mo./Day/Yr.)	Has this impairment(s) been continuous since the above date? <input type="checkbox"/> No <input type="checkbox"/> Yes

DIAGNOSIS	AHA / AMA CLASSIFICATION; GRADE / STAGE OF MALIGNANCY	PROGNOSIS
		Short Term:
		Long Term:
		Short Term
		Long Term:
		Short Term:
		Long Term:

History of Symptoms, Accidents, Surgeries, Referrals, etc.:
Present Complaints:
Present Functional Limitations:

NAME:

SSN:

Please define the extent of your patient's functional capabilities and activities of daily living. Include in your description such activities as self-care, communication, ambulation, pounds lifted, range of motion, and time standing and sitting. A detailed description of your patient's activities of daily living is needed.

Office visits during the last two years:

First visit:

Last visit:

Frequency of visits:

Weekly

Monthly

Other (explain)

### HOSPITALIZATION

(Please send all records)

Name of Hospital	Admission Date	Discharge Date	Discharge Diagnosis

### CLINICAL FINDINGS

(Please send chart notes and consultative reports)

Height: (without shoes)	Present Weight: (without shoes)	Date: (Mo./Day/Yr.)
Weight change of 10 lbs. or more? <input type="checkbox"/> No <input type="checkbox"/> Yes	Date:	Cause:

Course(s) of treatment and patient response: (Inclusive dates, referrals, medication, surgical interventions, radiation/physical therapy, special diet, etc.)

NAME:

SSN:

Does this patient have an impairment? Physical:  No  Yes Mental:  No  Yes

IF "YES" TO ONE OR BOTH OF THE ABOVE, PLEASE COMPLETE THE FOLLOWING:

What is the underlying etiology of the impairment?

FUNCTION	DEGREE OF IMPAIRMENT				<u>RESIDUAL ABILITIES</u>
	NONE	MILD	MODERATE	SEVERE	
Cognitive Ability					Sitting: _____ hours Standing: _____ hours Walking: _____ blocks Lifting: _____ pounds
Mental Status					
Hearing					
Vision					
Speaking					
Respiration					
Bending					
Handling / Fingering					
Reaching					
Stamina (fatigue)					
Pain Factor					
Other					

How and why does the impairment prevent your patient from performing a normal range of activities?

What is your estimate of the future duration of your patient's impairment?

- 0 – 3 Months       9 – 11 Months  
 4 – 8 Months       12 + Months

The impairment is:

- Temporary       Permanent  
 Terminal

Check any self-accommodation aids being used by the patient that were prescribed and indicate the specific type: (i.e., motorized wheelchair, Canadian crutches, etc.)

- Wheelchair       Walker       Crutches       Cane       Other  
 Brace       Hearing Aid(s)       Visual Acuity Aid       Prosthesis

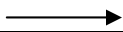
If there are other aids the patient could be using to improve his/her functioning: please describe,

Is patient able to perform his/her present employment or any other full-time employment while undergoing treatment or therapy for this impairment?  No  Yes - If yes, please explain:

- Without Restriction  
 Sedentary  
 Semi-Sedentary

NAME:

SSN:

Please comment on the following:  In a few selected disability cases in which the patient's psychiatric or medical condition might improve with ongoing therapy or treatment, CalSTRS requires the patient to undergo a continuous prescribed course of treatment as a condition of receiving continued disability benefit payments. The intent of the program is for patients to undergo treatments that they may otherwise be reluctant to undertake. It is hoped that eventually the patient will return to gainful employment.  If this person's psychiatric or medical condition would improve with ongoing therapy and treatment under a prescribed treatment program, please explain and indicate how often treatment or therapy should be instituted per month to achieve improvement.	
Additional Comments:	
Would you discuss this case with our analytical staff if they telephoned you?  <input type="checkbox"/> No <input type="checkbox"/> Yes 	If yes, what days and times are you available for Telephone calls?

**PLEASE INCLUDE COPIES OF YOUR CLINICAL NOTES WITH THIS REPORT**

<b>CERTIFICATE</b>	
I, the undersigned, a practicing licensed physician or therapist, hereby certify under penalty of perjury, that my answers to the foregoing questions are complete and true to the best of my knowledge, information and belief.	
Name: (Print or Type)	Address: (Number and Street)
License Number:	(City):
Medical Specialty:	(State):
Board Certified: <input type="checkbox"/> No <input type="checkbox"/> Yes	Telephone Number: (    )    -
Physician Signature:	Date: (Mo./Day/Yr.)