MSRS Minnesota State Retirement System

Medical Statement
Correctional Retirement Plan

Two medical statements must be provided as evidence of an illness, injury or condition.

- One statement must be completed by a licensed and practicing physician (MD).
- The second statement must be completed by another medical professional such as a licensed and practicing physician (MD), physician assistant, psychologist, nurse practitioner (APRN), chiropractor or podiatrist.

All medical information is reviewed by the MSRS medical advisors. Approval of a disability benefit is determined by the Executive Director of the Minnesota State Retirement System (MSRS) based on the recommendation of MSRS' medical advisors.

A narrative statement will be accepted in lieu of this form if all questions presented are addressed, opinions are clearly stated, and it is signed and dated by a **practicing physician**, **physician assistant**, **psychologist**, **nurse practitioner (APRN), chiropractor, or podiatrist**.

Submit supporting clinical findings and other evidence including laboratory and diagnostic tests.

After approval of a disability benefit, the employee's disability status may need to be **recertified** by a medical professional **once a year for the first five years** and **once every three years thereafter** until they reach full retirement age.

Definition of Correctional Retirement Plan Occupational Disability:

State law defines disability as a physical or psychological condition lasting at least one year that prevents a member from performing normal job duties. There are two types of disability:

- **Duty-related disability**. An injury must be incurred or a disease must arise while performing normal or less frequent duties that present inherent danger and are specific to a position covered by the plan.
- **Regular disability**. An injury may be incurred or a disease may arise from activity while not at work, or while at work and performing normal or less frequent duties that do not present inherent danger and are specific to a position covered by the plan.

1. Patient information

Last name	First name	MI
MSRS ID or SSN	Date of birth	

2. Medical information

1. Primary disabling condition:

   International Classification of Diseases (ICD) Code: _____

2. Onset of disabling condition: ____/____/____ (Month Day Year)

3. Most recent examination for disabling condition: ____/____/____ (Month Day Year)

4. How long have you treated this patient? From ____/____/____ (Month Day Year) To ____/____/____ (Month Day Year)

5. How long have you treated this patient for this disabling condition? From ____/____/____ (Month Day Year) To ____/____/____ (Month Day Year)

6. Frequency of office visits for disabling condition: ❒ Monthly ❒ Quarterly ❒ Semi-Annually ❒ Annually

7. List the medical providers most familiar with your patient's disabling condition:

Medical Providers or Clinic	Specialty	Dates of Medical Appointment First	Most Recent

8. Clinical findings that support disabling condition: _____

_____

_____

9. Laboratory and diagnostic tests relevant to disabling condition: _____

_____

10. Describe the current and past treatment plans, including medications:

❒ See attachment for current/past treatment plans, including medications.

	Date	Treatment Plan	Medications
Current Treatment Plan			
Past Treatment Plan			

11. Has the patient shown improvement with current treatment plan?

❒ Yes Level of improvement? ❒ Fair ❒ Moderate ❒ Good ❒ Excellent

❒ No

12. Describe the prognosis for the patient's disabling condition:

Over next 12 months: _____

Long-term: _____

13. In your opinion, is this patient occupationally disabled as defined on page 1?

❒ Yes Date the patient's disability began ____/____/____ (Month Day Year)

❒ No Patient may resume employment on ____/____/____ (Month Day Year)

Psychiatric capabilities - **if applicable**

❒ Assessment attached

	Describe Capabilities	Level of Impairment
Ability to comprehend and follow instructions		❒ None ❒ Slight ❒ Moderate ❒ Marked
Ability to perform simple and repetitive tasks		❒ None ❒ Slight ❒ Moderate ❒ Marked
Ability to maintain a work pace appropriate to a given workload		❒ None ❒ Slight ❒ Moderate ❒ Marked
Ability to perform complex or varied tasks		❒ None ❒ Slight ❒ Moderate ❒ Marked
Ability to relate to other people beyond giving and receiving instructions		❒ None ❒ Slight ❒ Moderate ❒ Marked
Ability to influence people		❒ None ❒ Slight ❒ Moderate ❒ Marked
Ability to make generalizations, evaluations or decisions without immediate supervision		❒ None ❒ Slight ❒ Moderate ❒ Marked
Ability to accept and carry out responsibility for direction, control and planning		❒ None ❒ Slight ❒ Moderate ❒ Marked

In your opinion, based on your knowledge, personal contact, and observation of your patient, what type of work and work environments would be conducive for your patient to return to work?

Physical capacity - **if applicable**

❒ Assessment attached

Please address all below	Indicate **MAXIMUM** capacity in pounds	Not applicable	**OCCASIONAL** 0 to 2.6 hours per day	FREQUENT 2.7 to 5.3 hours per day	CONSTANT 5.4 to 8.0 hours per day
Low lift (floor to knuckle)					
Mid lift (knuckle to shoulder)					
Full lift (floor to shoulder)					
Carrying					
Pushing					
Walking					
Climbing					
Balancing					
Stooping					
Kneeling					
Crouching					
Crawling					
Reaching (immediate)					
Reaching (overhead)					
Handling					
Fingering					
Feeling					
Sitting					
Standing					

Physical Capacity

Please indicate your patient's physical capacity based on the definition in the **Department of Labor's Dictionary of Occupational Titles**:

❒ **Sedentary**

Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

❒ **Light**

Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, you must have the ability to do substantially all of these activities. If someone can do light work, we determine that they can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.

❒ **Medium**

Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, we determine that they can also do sedentary and light work.

❒ **Heavy**

Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, we determine that they can also do medium, light, and sedentary work.

❒ **Very Heavy**

Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. If someone can do very heavy work, we determine that they can also do heavy, medium, light and sedentary work.

3. Medical provider's signature

This statement may be signed only by a practicing physician, physician assistant, psychologist, nurse practitioner (APRN), chiropractor or podiatrist.

I, the undersigned, a practicing physician, physician assistant, psychologist, nurse practitioner (APRN), chiropractor or podiatrist duly registered under the laws of the state in which I practice, do hereby certify that my answers to the foregoing questions are true and complete to the best of my knowledge, information and belief.

Name _____ Specialty _____
Please print name

Signature _____ Medical title _____

Date _____ Phone number _____ Fax number _____

Primary office contact name _____

Primary office contact title _____ Phone # if different from above _____

Street address _____

City _____ State _____ Zip code _____

ABMS Board Certified ❒ Yes ❒ No

Mail or fax the completed form to:

Minnesota State Retirement System
60 Empire Drive, Suite 300
St. Paul, MN 55103-3000

Toll-free: 1.800.657.5757

Fax: 651.227.5337

Teletypewriter users and telecommunications-device-for-the-deaf (TDD) users call the Minnesota Relay Service at 1.800.627.3529 and ask to be connected to MSRS at 651.296.2761.