STATE RETIREMENT SYSTEMS

- State Employees' Retirement System of Illinois
- General Assembly Retirement System
- Judges' Retirement System of Illinois

Internet: *http://www.state.il.us/srs* E-Mail: *sers@srs.illinois.gov*

2101 South Veterans Parkway, P.O. Box 19255, Springfield, IL 62794-9255

TEMPORARY DISABILITY

DEAR DOCTOR:

THE EMPLOYEE NAMED BELOW HAS MADE APPLICATION FOR DISABILITY BENEFITS FROM THE STATE EMPLOYEES' RETIREMENT SYSTEM. PLEASE COMPLETE AND RETURN THIS FORM TO THE ABOVE ADDRESS. THE EMPLOYEE'S ELIGIBILITY FOR BENEFITS CANNOT BE DETERMINED UNTIL WE RECEIVE THIS INFORMATION.

EMPLOYEE: **BIRTH DATE:**

SOCIAL SECURITY NUMBER: ☐☐☐☐☐☐☐☐☐☐☐

DIAGNOSIS AND CONCURRENT CONDITIONS: _____

_____

_____

PLEASE LIST RESULTS OF APPROPRIATE LABORATORY STUDIES: _____

_____

_____

PLEASE LIST OBJECTIVE SYMPTOMS AND FINDINGS (Please be specific, i.e., B/P reading, or attach a copy of patient's charts): _____

_____

_____

NATURE OF TREATMENT AND DATES: (Enclose your statement if more convenient)

_____

_____

HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY MEDICALLY UNABLE TO WORK:
FROM: _____ , 20____ TO:_____ , 20 ____
ESTIMATED RETURN TO WORK DATE: _____ , 20 ____

REMARKS: _____

_____

_____

THE ABOVE NAMED INDIVIDUAL APPEARED BEFORE ME FOR MEDICAL EXAMINATION.
THE DIAGNOSIS, TREATMENT AND REMARKS ARE MY PROFESSIONAL OPINION.

SIGNATURE: _____ DATE: _____
ADDRESS: _____ REGISTRATION NUMBER: _____
TELEPHONE NUMBER: _____