

**Manchester Employees' Contributory Retirement System
ATTENDING PHYSICIAN'S STATEMENT**

Name of Patient _____

Address _____

City, State, Zip Code _____

HISTORY:

A. When did present illness begin, or injury occur? _____

B. Date insured was obliged to cease work? _____

C. Was disability sustained in the course of performance of duties as a City Employee? _____

D. Was disability the result of non-employment factors (e.g. medical history)? _____

PRESENT CONDITION:

A. Subjective symptoms: _____

B. Objective findings: _____

- Give report of X-rays, E.K.G.'s or any other special tests

Ambulatory?....() Bed confined?....() House confined?....() Hospital confined?...()

DIAGNOSIS: _____

TREATMENT:

A. Date of first visit: _____ Date of last visit: _____ Frequency of visits: _____

B. When did you last examine the insured? _____

PROGRESS:

Recovered.....() Improved.....() Unimproved.....() Retrogressed.....()

DEGREE OF DISABILITY:

A. Has the insured been able to do any of his/her regular work? Yes.....() No.....()

If "Yes", from what date?

Regular Work: ____ / ____ / ____ Comparable Work: ____ / ____ / ____

B. If "No", when do you think he/she will be able to work? (Approximate Date)

Regular Work ____ / ____ / ____ Comparable Work: ____ / ____ / ____

Indefinite.....() Never.....()

C. Is patient 100% totally and permanently disabled from performing the duties of a position comparable in duties and responsibilities held prior to disability? Yes___No___

Additional Comments: _____

Name of Attending Physician: _____

Address: _____

Signature: _____

Date: _____