PHYSICIAN'S STATEMENT—DISABILITY CLAIM

IMRF Form 5.42 (Rev. 10/2017) ***Please print—use black ink***

IMRF requires a separate Form 5.42 from each physician who is certifying your disability

Do NOT submit this form if the patient is still able to work.

Patient's Last Name	First	Middle Initial	Jr., Sr., II, etc.	IMRF Member ID **OR** Last 4 Digits of SSN

Birth Date	Patient's Occupation

MANDATORY INFORMATION

*This section in the red box **MUST** be completed **fully**. If this information is not provided **the form will not be processed.***

Diagnosis and concurrent conditions:

ICD 9 Code(s) _____

Report of Treatments or Services. (*Failure to attach **Office Notes** will delay processing of this claim*)

Date(s)	Place (give name and address of hospital)—also list office visits	Description of Surgical or Medical Services Rendered

Date of next evaluation:

Patient was continuously disabled (unable to work): ***NOTE: This form is INVALID without a "From" Date below***

FROM _____ **THROUGH** _____

You must attach office visit notes/medical records to your completed form.

Is condition due to: Injury or sickness arising out of patient's employment? ☐ Yes ☐ No

Is disability due to an accident? ☐ Yes ☐ No **If yes**, date of accident:

Did you recommend this patient stop working? ☐ Yes ☐ No **If yes**, indicate date:

Date symptoms first treated _____ Describe any complications:

Patient ever had same or similar condition? ☐ Yes ☐ No **If yes**, indicate date(s) and describe:

Is patient now able to return to work in full duty capacity or with work restrictions? ☐ Yes, Full Duty ☐ Yes, w/Restrictions ☐ No

List any restrictions/limitations: **If yes,** indicate return date _____

If still disabled, what is principal cause of disability?

MANDATORY/VALID SIGNATURE, by licensed, practicing physician only.

By signing, I certify that this information is correct. I am aware that pursuant to the Illinois Pension Code, 40 ILCS 5/1-135, any person who knowingly makes any false statement or falsifies or permits to be falsified any record in an attempt to defraud IMRF is guilty of a Class 3 felony. If the IMRF Board has a reasonable suspicion that a false record has been filed with the Fund, it is required to report the matter to the appropriate state's attorney for investigation.

Physician's Signature (*NOTE: Form will **not be processed** without Mandatory/Valid signature.*)	Date

Physician's Name	Degree/Specialty	Telephone:
		Fax:
Street (Mailing) Address	City, State and Zip	Email:

IMRF
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