

Dallas Police and Fire Pension System

Attending Physician's Statement

If space provided is insufficient, please attach supplementary information to this evaluation.

Purpose: The following questions are presented to assist the physician/psychiatrist in providing information to the Dallas Police and Fire Pension System ("System") that is necessary for a determination of whether a Member is disabled for purposes of entitlement to disability benefits; and, if so, whether the disability is service connected. We believe that this information also will allow the System to establish an appropriate recall period to reevaluate the status of the Member's disability, provide relevant information to the City of Dallas ("City") so that the City may determine whether the Member may be suitably employed in another position, and assist the City in any determination of the reasonable accommodations necessary for employment of the Member.

THESE MATTERS HAVE SIGNIFICANT ECONOMIC IMPLICATIONS TO BOTH YOUR PATIENT AND THE SYSTEM. YOUR DILIGENCE IN PROVIDING ALL THE REQUESTED INFORMATION AND ANY OTHER INFORMATION THAT YOU BELIEVE MAY BE RELEVANT TO THIS MATTER, IS THEREFORE, GREATLY APPRECIATED.

Member's name _____

Social Security number _____

1. Date(s) of consultation _____
2. Completely describe the Member's relevant personal and family medical/psychiatric history prior to the onset of the illness or injury and through to the date of this evaluation.

3. What are the factors that you believe contributed to Member's illness or injury? To the extent possible, please describe in detail the basis upon which you determined causation. Also, include all information (such as tests, physical observation, patient's commentary, etc.) you relied on in making your determination.

1. _____

2. _____

3. _____

4. _____

etc. _____

4. What is the date of injury or onset of illness? To the extent possible, please describe the basis upon which you determined the date of injury or illness in detail and include all of the information (such as tests, physical observation, patient's commentary, etc.) you relied on in making your determination.

5. Findings:

(a) Subjective

(b) Objective

6. Please describe in detail the evidence you relied upon for such assessment, diagnosis and prognosis of the Member's physical/psychiatric condition.

7. In your opinion, is the present injury or illness service-connected or not service-connected? To the extent possible, please describe in detail the basis upon which you determined that the injury or

13. In your opinion, is the Member's condition temporary or permanent?

Please provide a detailed explanation of why you believe the Member's condition is temporary or permanent.

14. If you believe that the Member's condition is temporary, when would you expect the Member to be capable of resuming the duties described in Attachment "A" to this Statement?
15. If you believe that the Member's condition is temporary, when would you expect the Member to be capable of performing the sedentary duties described in Attachment "B" to this Statement?
16. Would you or have you recommended any type of treatment or therapy to the Member? Please describe in detail the kind of treatment or therapy that you have or would recommend.
17. Please explain whether the anticipated date of the Member's resumption of the duties described in Attachment "A" to this Statement would be different if the Member underwent the recommended treatment or therapy.

18. If the Member underwent the recommended treatment or therapy, would any accommodation(s) be necessary to permit the Member to resume the duties described in Attachment "A" to this Statement? Explain the basis of your opinion.

19. If the Member underwent the recommended treatment or therapy, would any accommodation(s) be necessary to permit the Member to perform the sedentary duties described in Attachment "B" to this Statement? Explain the basis of your opinion.

20. When would you recommend the Member undergo a follow-up evaluation of his/her disability? Please explain the basis for such recommendation.

21. If no treatment or therapy has been recommended, please explain in detail the reason(s) (including any medical reason) for refraining from making the recommendation.

22. If the Member is applying for a psychiatric disability, did the Member undergo psychiatric/psychological evaluation and/or testing? If so, please provide copies of related psychiatric/psychological evaluation(s) and test(s) and summarize their results below.

23. If no such psychiatric/psychological evaluation and/or testing has been performed, please explain the reason the evaluation and/or testing was not performed.

I hereby certify that I evaluated _____ (name)
on _____ (date),
and that his or her condition is accurately described above.

Please attach any supplemental narrative information, all medical, laboratory, and x-rays, and other relevant reports to this statement.

Signed _____

Date _____

Physician's name (please print) _____

Address _____

City _____ State _____ ZIP _____

Telephone _____

The Member's disability application will not be considered by the Board of Trustees of the Dallas Police and Fire Pension System until all of the questions on this form have been answered in full. Call 214.638.FUND (3863) if you have any questions about this form.

Dallas Police and Fire Pension System, 4100 Harry Hines Blvd., Suite 100, Dallas, Texas 75219.