KPERS

KP&F-538 Rev. 2/14

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PHYSICIAN'S REPORT OF MEMBER CONDITION

■ **Contact Us – toll free**: 1-888-275-5737 • **phone**: 785-296-6166 • **fax**: 785-296-6638
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■ Part A – Member Information

1. Social Security Number: _____ 2. Name (First, MI, Last): _____
3. Mailing Address: _____

   City, State, Zip: _____

■ Part B – Member Certification

1. Date sickness or injury caused you to quit work entirely (mo/day/yr): _____
2. I hereby authorize any physician who has attended me or who may attend me, or any hospital where I may have been a patient, to disclose any information thus acquired to the Kansas Police & Firemen's Retirement System or its representative, at no expense to the Retirement System. A photocopy of this authorization shall be considered valid as the original.

   Member Signature: _____ Month/Day/Year: _____/_____/_____

■ Part C – Physician's Statement –

The patient is responsible for the completion of this form without expense to the Kansas Police and Firemen's Retirement System. Disability is defined by the Kansas Police and Firemen's Retirement Act, K.S.A. 74-4952(2) as "the total inability to perform permanently the duties of the position of a policeman or fireman."

1. **History**
   (a) Date patient became disabled (mo/day/yr): _____
   (totally unable to perform the duties of his/her position as a police officer or firefighter)
   (b) Date patient ceased work because of disability (mo/day/yr): _____
   (c) Has patient ever had the same or a similar condition? ❒ Yes ❒ No
   If yes, please state when and describe: _____

2. **Present Condition**
   (a) Subjective symptoms: _____
   (b) Objective findings (include results of current X-rays, E.K.G.'s, or any other special tests): _____
   (c) Is patient: ❒ Ambulatory ❒ Bed-confined ❒ House-confined ❒ Hospital-confined?

3. **Diagnosis**

4. **Treatment**
   (a) Date of First Visit: _____
   (b) Date of Last Visit: _____
   (c) Frequency of visits: ❒ Weekly ❒ Monthly ❒ Other
   (d) When did you last examine the patient? _____

5. **Progress**

❒ Recovered ❒ Improved ❒ Unimproved ❒ Retrogressed

6. **Mental Condition**

Is the patient competent to endorse checks and direct the use of the proceeds thereof? ❒ Yes ❒ No

7. **Cause of Disability**

Was patient's disability a result of an accident or act of duty on the job? ❒ Yes ❒ No

If "yes," please give the date or dates of accident or act of duty: _____

8. **Extent of Disability**

(a) Is patient now totally disabled for the duties of his/her current position under the Kansas Police and Firemen's Retirement System? ❒ Yes ❒ No

(b) If "no," when was the patient able to go to work? _____

(c) If "yes," when do you think the patient will be able to resume work as a police officer or firefighter?

Approximate Date: _____ ❒ Indefinite ❒ Never

9. Complete this item if the disability is due to **cardiac condition**.

(a) Functional capacity (American Heart Association): ❒ Class 1 (no limitation) ❒ Class 2 (slight limitation) ❒ Class 3 (marked limitation) ❒ Class 4 (complete limitation)

(b) Blood pressure: _____

10. **Remarks**: _____

_____

_____

_____

_____

Physician Signature: _____ Month/Day/Year: _____/_____/_____

Physician's Name (Please Print): _____

Telephone Number: _____ Address: _____

City, State, Zip: _____

NOTE: K.S.A. 74-4924 provides: "Any person who shall knowingly make any false statement, or who shall falsify or permit to be falsified any record necessary for carrying out the intent of this act for the purpose of committing fraud, shall be subject to the provisions of K.S.A. 21-3904 and amendments thereto."