



PENSIONS ADMINISTRATION DIVISION
Department of Finance, P.O. Box 8700, St. John's, NL, A1B 4J6
Fax (709) 729-6790

ASSESSMENT FOR MEDICAL DISABILITY RETIREMENT

NAME _____ SIN _____
DATE OF BIRTH _____ EMPLOYER _____

NOTE TO PHYSICIANS:
PLEASE BE THOROUGH WHEN COMPLETING THIS FORM AS IT WILL BE USED TO
DETERMINE WHETHER THE PLAN MEMBER QUALIFIES FOR A LIFETIME
DISABILITY PENSION.

A pre-requisite for medical retirement is that the plan member is unable to perform efficiently the duties of his/her position or the duties of an alternate position owing to a condition that is medically certified as likely to be permanent.

Alternate Position means any employment for which the employee is reasonably suited by virtue of education, training or experience. This is not applicable under the Teachers' Pensions Act.

I hereby authorize the release of the medical information as requested herein for the purpose of determining my eligibility for retirement on medical grounds.

Signature of applicant or representative

Date _____

Assessment for Medical Disability Retirement

1. Diagnoses (in order of significance)

A. _____ B. _____
C. _____ D. _____

Objective Findings (including results of recent x-rays, laboratory reports or any other special tests)

2. History

A. When did symptoms first appear or accident occur? _____
B. Date total disability commenced? _____
C. Is disability due to injury or sickness resulting from the applicant's employment? _____

3. Treatment

A. Date of first visit? _____
B. Date of latest visit? _____
C. Is the applicant following a recommended treatment program? Yes No

4. Physical Impairment

Is applicant: house confined bed confined hospital confined Other

Are there other contributing factors to the applicant's disability, e.g. obesity, substance abuse? Yes No

Please Explain: _____

Assessment for Medical Disability Retirement

5. Effect of Medical Condition on Performance of Duties

Please explain the extent to which the applicant's disability affects his/her capacity to:

- A. Perform his/her regular duties _____

- B. Perform duties of an alternate position for which the applicant may be qualified

If this disability is stress related due to employment, would an alternate position relieve symptoms?

6. Prognosis

- A. Does disability prevent the applicant from ever performing the duties of his/her regular occupation? Yes No
alternate position Yes No *(Not applicable to Teachers' Pension Plan)*

- B. If no, please indicate when you would expect the applicant to recover sufficiently to perform duties on a total or partial basis? _____

- C. If "yes" please indicate date of total disability. _____

Assessment for Medical Disability Retirement

7. Rehabilitation

- | | Regular
Occupation | Alternate Position
(N/A Teacher's Plan) |
|--|--|--|
| A. Is the applicant a suitable candidate for trial employment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| B. If yes when could trial employment
Commence? | | |
| | <input type="checkbox"/> Full-time _____ | |
| | <input type="checkbox"/> Part-time _____ | |
| C. If "no" please explain | _____ | |
| | _____ | |
| D. Would vocational counseling and/or training be recommended? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

8. Briefly state in "lay persons" terms why you feel this applicant's disability will prevent his/her return to active employment.

Physician's Name (Please print) _____	
Address _____	Telephone _____
_____	_____
Signature _____	Date _____
Certified Specialist <input type="checkbox"/> Yes <input type="checkbox"/> No	



APPLICATION FOR MEDICAL DISABILITY RETIREMENT

PENSIONS ADMINISTRATION DIVISION
Department of Finance, P.O. Box 8700, St. John's, NL, A1B 4J6
Fax (709) 729-6790

TO: THE MINISTER OF FINANCE

I, _____, of _____
(Name of Plan Member) (Employer)

_____ hereby apply for medical disability retirement in accordance with the terms and conditions of :

- The Public Service Pensions Act, 1991
- The Teachers' Pensions Act, 1991
- The Uniformed Services Pensions Act, 1991

Home Address: _____

Home Telephone: _____ Date of Birth: _____
(YYYY/MM/DD)

SIN _____ Occupation: _____

Signature: _____

Date: _____



CONSENT FOR RELEASE OF MEDICAL INFORMATION

PENSIONS ADMINISTRATION DIVISION
Department of Finance, P.O. Box 8700, St. John's, NL, A1B 4J6
Fax (709) 729-6790

I, _____, of _____
(Name of Plan Member) (Address)

an employee of _____, agree
(Name of Employer)

to permit my attending physician(s) _____, _____
(Name of Physician) (Telephone)

OR the Medical Records Department of the _____
(Name of Hospital)

To release any medical information requested to Dr. C. O'Shea, (or his designate), Medical Advisor to the Department of Finance, Pensions Administration Division, pertaining to my application for medical disability retirement. Any costs associated with the release of medical information from my doctor(s) to the Medical Advisor will be borne by me. I understand that this information will be treated confidentially.

To help ensure correct identity and prompt delivery of medical information, my Date of Birth and MCP# are as follows:

Date of Birth _____

MCP# _____

Other Attending Physicians

(Name) (Telephone)

(Name) (Telephone)

(Name) (Telephone)

NOTE: IF THE FULL NAME AND TELEPHONE NUMBER OF THE PHYSICIAN IS NOT PROVIDED IT MAY RESULT IN DELAYS IN PROCESSING THE APPLICATION

Signed: _____

Witnessed: _____

Dated: _____