

B. ABOUT YOUR MEDICAL RECORDS

1. Please furnish the following information regarding caregivers (for example, doctors, psychologists, therapists) who have treated you for the condition(s) for which you now receive disability retirement benefits and for all conditions which you believe are related to, or caused by, the disabling condition. List only those caregivers who have treated you since you applied for MSRS disability benefits.

a. _____
CAREGIVER'S NAME SPECIALTY

STREET OR BOX NUMBER CITY/TOWN STATE ZIP CODE

CAREGIVER'S TELEPHONE NUMBER DATE YOU FIRST SAW THIS CAREGIVER DATE YOU LAST SAW THIS CAREGIVER

b. _____
CAREGIVER'S NAME SPECIALTY

STREET OR BOX NUMBER CITY/TOWN STATE ZIP CODE

CAREGIVER'S TELEPHONE NUMBER DATE YOU FIRST SAW THIS CAREGIVER DATE YOU LAST SAW THIS CAREGIVER

c. _____
CAREGIVER'S NAME SPECIALTY

STREET OR BOX NUMBER CITY/TOWN STATE ZIP CODE

CAREGIVER'S TELEPHONE NUMBER DATE YOU FIRST SAW THIS CAREGIVER DATE YOU LAST SAW THIS CAREGIVER

2. Please furnish the following information regarding hospitals or clinics where you have been treated for the condition(s) for which you now receive disability retirement benefits and for all conditions which you believe are related to, or caused by, the disabling condition. List only those caregivers who have treated you since you applied for MainePERS disability benefits.

a. _____
NAME OF INSTITUTION TELEPHONE NUMBER

STREET OR BOX NUMBER CITY/TOWN STATE ZIP CODE

DATE(S) OF TREATMENT

b. _____
NAME OF INSTITUTION TELEPHONE NUMBER

STREET OR BOX NUMBER CITY/TOWN STATE ZIP CODE

DATE(S) OF TREATMENT

c. _____
NAME OF INSTITUTION TELEPHONE NUMBER

STREET OR BOX NUMBER CITY/TOWN STATE ZIP CODE

DATE(S) OF TREATMENT

C. EDUCATION AND TRAINING

1. Please indicate your highest grade level completed:

- some high school high school graduate some college
 2-year college degree 4-year college degree Masters or other post graduate

Other, explain _____

2. List any additional courses you have attended and certificates attained: _____

3. List any licenses you hold: _____

4. List other specialized training or schooling you have completed: _____

D. ABOUT YOUR WORK

1. When did you last see the doctor who treats you for the condition(s) for which you now receive disability benefits? _____

a.) Has your doctor told you that you are able to return to your prior employment? Yes No

b.) Has your doctor told you that you are able to return to some type of work? Yes No

If "Yes," to either a.) or b.) please give doctor's name and address: _____

2. Do you think your medical condition has improved so that you are able to return to any type of work?

- Yes No

3. What date did your doctor tell you that you could return to work? _____

4. Did the doctor restrict you to limited or part-time work? Yes No

If "Yes," please explain: _____

5. Have you engaged in any work activity since your retirement? Yes No

If "Yes": number of hours worked per week _____ amount of hourly pay _____ dates of employment _____

What are/were your duties? _____

Place of employment: _____

If no longer working, when and why did you leave? _____

6. Please list any additional remuneration you received from an employer such as sick pay, vacation pay, bonuses, commissions, etc. _____

E. OTHER COMPENSATION

Are you receiving: Workers' Compensation? Yes No

If yes, amount received monthly \$ _____ If "Yes," for what disability? _____

Social Security Disability benefits? Yes No

If yes, amount received monthly \$ _____ If "Yes," for what disability? _____

Unemployment Compensation? Yes No

If yes, amount received weekly \$ _____

Other Income? Yes No

If "Yes," please explain: _____

F. VOCATIONAL REHABILITATION

Are you receiving services from a vocational rehabilitation agency? Yes No

If "Yes,": What kind of help have you received, or do you expect to receive (i.e. counseling, job development, etc.)?

When did you receive, or expect to receive, this help? _____

What is the name and address of your vocational rehabilitation counselor? _____

I hereby certify that the above statements are true. I understand that the medical records supplied by the caregivers identified above may constitute the sole basis for determining my eligibility to continue to receive disability benefits. MainePERS may, at its discretion and at its expense, require further medical examination(s) prior to making a final determination.

In accordance with 5 MRSA §17057 (3), home contact information of Retirement System members, benefit recipients or staff members that are in the possession of the Retirement System are confidential. This information is not open to public inspection and not considered to be a matter of public record as defined in Title 1, §401 (3). For purposes of this statute "home contact information" means a home address, a home telephone number, home facsimile transmission number or home e-mail address.

I hereby authorize the release of my home contact information as defined above for the duration of the processing of my review for the continuation of my disability benefit, including the period of time needed for any appeal resulting from my review for disability benefits. I may not designate selective release of my home contact information. I further understand that MainePERS is not responsible for the manner in which home contact information is used by an entity other than the Retirement System.

SIGN
HERE 

DATE
HERE 

PLEASE NOTE: If this form is being filled out by someone besides the recipient, please sign above and explain below:

YOUR NAME (PRINT OR TYPE)

RELATIONSHIP

PLEASE EXPLAIN WHY YOU'RE FILLING OUT THIS FORM FOR APPLICANT

NOTE: If you are the recipient's Legal Guardian, Appointed Representative or hold a Power of Attorney, please attach a copy of the document giving you this designation.