SERS
State Employees' Retirement System

2101 South Veterans Parkway
P.O. Box 19255
Springfield, IL 62794-9255

217-785-7444
Fax: 217-785-6961
Email: sers@srs.illinois.gov

Temporary Disability Medical Report

The employee named below has applied for disability benefits from the State Employees' Retirement System. Please complete and return this form using the contact information above. The employee's eligibility for benefits cannot be determined until we receive this information. ***This form is acceptable only if completed by a licensed healthcare professional.***

Employee information

Name _____ **Date of birth** _____

SSN _____

Medical information

Diagnosis and concurrent conditions: _____

Please list results of appropriate diagnostic studies: _____

Please list objective symptoms and findings: *(Please be specific, i.e., B/P reading, or attach a copy of patient's charts)* _____

Nature of treatment and dates: *(Enclose a copy of your office records if more convenient)* _____

Onset date of disability: _____ **Date the patient's impairment kept them from working?** _____

Is the patient still under your care for the diagnosis listed above? ☐ Yes ☐ No

Date patient is released to return to work: _____

Restrictions: _____

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

The above named individual appeared before me for medical examination. The diagnosis, treatment and remarks are my professional opinion.

Printed name _____ **Date** _____

Signature _____ **Specialty** _____

Registration Number _____ **Phone** _____

Address _____ **Fax** _____