maine PERS Public Employees Retirement System
P.O. Box 349
Augusta, ME 04332-0349
Telephone: (207) 512-3170
Toll-free: 1-800-451-9800
Fax: 207-512-3285
TTY: (207) 512-3102

**FORM 3**

# MEDICAL CERTIFICATION FOR DISABILITY BENEFITS

Disability Recipient: _____

Last Four Digits of SSN: _____ Date of Birth: _____
MM/DD/YYYY

The above-named individual receives disability retirement benefits based upon the following conditions:

For this individual to continue to receive disability retirement benefits, the medical condition(s) listed above must continue to exist and result in functional limitations. Conditions that are directly caused by the condition for which disability benefits were granted, and functional limitations which result from these related conditions may also be considered in evaluating the person's eligibility to continue receiving disability benefits.

For each condition listed above, and for any conditions that are directly caused by that condition, state the functional limitations that arise.

1. Condition: _____

   Functional limitations: (i.e., how symptoms impair work capacity) _____

   _____

2. Condition: _____

   Functional limitations: (i.e., how symptoms impair work capacity) _____

   _____

I certify that _____ is my patient and that:

1. The functional limitations that I have attributed to him/her are based upon my objective findings during an examination of him/her. _____
   Date of Exam

   Physician Name: _____ Medical Specialty: _____

OR

2. The functional limitations that I have attributed to him/her are based in part upon my examination and in part on findings based on consultation with another physician or physicians.

   _____
   Date of Exam

Names of other physician(s) whose consultations form part of the basis of this opinion:

_____

_____

_____

_____

_____

_____ _____

Physician's Name (printed) Specialty

_____ _____

Physician's Signature Date

**Please include twelve (12) months of office notes and an invoice for medical records.**

We are authorized to pay up to $5.00 for the first page of medical records and $0.45 per additional page for photocopies. On your invoice, please include your Federal tax identification number or Social Security number to insure prompt payment.

It is important that you realize that any information you send to us, including your office notes, may be disclosed to _____. Under certain conditions total confidentiality might not be possible, for example, in the event of an appeal. Therefore, if you have reason to believe that the release of information you send us might be harmful to _____ in any way, or if you have another basis upon which complete confidentiality should be maintained, you must state so in a letter included with the records. Your letter should clearly and fully inform us why the information should not be disclosed. Please note that form language stamped on or attached to the information prohibiting re-disclosure will not be sufficient to maintain the complete confidentiality of the records.