City of Tacoma
Tacoma Employees' Retirement System (TERS)
3628 S. 35th St., Tacoma, WA 98409 ▪ P.O. Box 11007, Tacoma, WA 98411-0007
Office: (253) 502-8200
Fax: (253) 502-8660

Application For Disability Retirement Part 2
Physician Information

Applicant Information			**Employee no._____**	
First Name	Middle Initial	Last Name	Social Security Number	
Mailing Address		City	State	Zip Code
Telephone Number	E-mail		Date of Birth	

☐ My incapacity for the performance of my duties was caused directly by an accident or event or incurred as a result of the actual performance of duties as an employee of the City of Tacoma.

☐ My disability is caused by the following medical condition. If more than one disabling condition exists, specify each:

_____

_____

Please provide a separate copy of this form (Part 2) to each personal physician.

Member: please provide your physician your most recent job description, as well as a description of other positions for which you are qualified.

Physician Statement (to be completed and signed by physician)

Note to Physician: All fields must be responded to by the treating physician. Answer each section to the best of your abilities and attach copies of any documents (charts, test results, lab findings, or other supporting evidence) that support your findings. Be as specific as you can with history, diagnosis and dates of treatment.

Treatment notes, test results and diagnosis should be for the specific disability the member is applying under.

Approval for TERS Disability Retirement requires a statement from an independent Board-appointed physician saying that the member is permanently and totally disabled. TERS will provide this report and attachments to the Independent Medical Examiner (IME) appointed by the Board.

Submit recent objective findings that document the nature and extent of the disability and support the conclusion in the Physician Conclusions section of the form. Examples of finding may include progress notes, consultations, independent medical evaluations, diagnostic imaging studies, etc. Please note or provide:

1) The length of time you have treated this patient for this condition.

2) A history of injury, occupational disease, or other disability for which this application is filed.

3) A history of previous injuries, occupational disease, or disability of some other nature.

4) Date(s) of treatment for present injuries, occupational disease, or other disability.

5) Findings on Examination (include result of diagnostic tests and lab findings, if any).

6) Complete the Physical Capacities Evaluation in Appendix A at the end of this form.

7) Diagnosis

Physician Conclusions (definite answers are required for all questions in this section)

1) Is the member totally incapacitated for continued employment? ☐Yes ☐ No

2) When did the member become totally incapacitated for continued employment? (mm/dd/yyyy)

3) Is the member's present total incapacity for continued employment likely to be permanent? ☐Yes ☐ No

If yes, do you have specific recommendation on what type of physician (specialty) the Board should retain to perform an Independent Medical Examination (IME)?

Recommended specialty for IME_____

Certification by Physician

Are you a Board-certified specialist? ☐Yes ☐ No

If yes, what is your specialty?_____

Signature _____ Date _____

APPENDIX A

City of Tacoma
Tacoma Employees' Retirement System
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PHYSICAL CAPACITIES EVALUATION

Name of Claimant

IMPORTANT: Please complete the following items based on your clinical evaluation of the claimant and other testing results. Any item that you do not believe you can answer should be marked N/A.

NOTE: In terms of an 8-hour workday, "Occasionally" equals 0% to 33%; "Frequently," 34% to 66%; "Continuously," 67% to 100%.

I. In an 8 hour workday, claimant can: (Circle full capacity for each activity)

A.	Sit	No ☐	1	2	3	4	5	6	7	8	(Hours)
B.	Stand	No ☐	1	2	3	4	5	6	7	8	(Hours)
C.	Walk	No ☐	1	2	3	4	5	6	7	8	(Hours)

II. Claimant can lift:

		Never	Occasionally	Frequently	Continuously
A.	Up to 10 lbs.	[ ]	[ ]	[ ]	[ ]
B.	11-20 lbs.	[ ]	[ ]	[ ]	[ ]
C.	21-50 lbs.	[ ]	[ ]	[ ]	[ ]
D.	51-100 lbs.	[ ]	[ ]	[ ]	[ ]

III. Claimant can carry:

		Never	Occasionally	Frequently	Continuously
A.	Up to 10 lbs.	[ ]	[ ]	[ ]	[ ]
B.	11-20 lbs.	[ ]	[ ]	[ ]	[ ]
C.	21-50 lbs.	[ ]	[ ]	[ ]	[ ]
D.	51-100 lbs.	[ ]	[ ]	[ ]	[ ]

IV. Claimant can use hands for repetitive action such as:

		Simple Grasping	Pushing & Pulling	Fine Manipulating
A.	Right	Yes [ ] No [ ]	Yes [ ] No [ ]	Yes [ ] No [ ]
B.	Left.	Yes [ ] No [ ]	Yes [ ] No [ ]	Yes [ ] No [ ]

V. Claimant can use feet for repetitive movements as in operating foot controls:

A.	Right	Yes [ ]	No [ ]
B.	Left.	Yes [ ]	No [ ]
B.	Both	Yes [ ]	No [ ]

VI. Claimant is able to:

		Not at All	Occasionally	Frequently	Continuously
A.	Bend	[ ]	[ ]	[ ]	[ ]
B.	Squat	[ ]	[ ]	[ ]	[ ]
C.	Crawl	[ ]	[ ]	[ ]	[ ]
D.	Climb	[ ]	[ ]	[ ]	[ ]
E.	Reach above shoulder level	[ ]	[ ]	[ ]	[ ]

VII. Restriction of activities involving:

		Not at All	Occasionally	Frequently	Continuously
A.	Unprotected heights	[ ]	[ ]	[ ]	[ ]
B.	Being around moving machinery	[ ]	[ ]	[ ]	[ ]
C.	Exposure to marked changes	[ ]	[ ]	[ ]	[ ]
D.	Driving automotive equipment	[ ]	[ ]	[ ]	[ ]
E.	Exposure to dust, fumes and gases	[ ]	[ ]	[ ]	[ ]

Remarks (on above or other functional limitations)

_____

_____

_____

_____ _____

Date **Signature of Physician**