Public Service Pension Plan

Confedential Medical Statement

The information on this form will assist PSPP in determining eligibility for disability pension benefits for the patient. No information, in whole or in part, will be released to any unauthorized person(s) without the patient's prior written consent. This statement will be held in strictest confidence and used solely to enable an assessment of the patient's disability by an independent medical consultant. The information on this form must be completed by a physician and returned to the patient. Charges for the completion of this report, if any, are the responsibility of the patient.

1. Patient Information

patient's first name _____ patient's last name _____ pension plan identification number _____

address _____

city, town, village, etc. _____ province/territory _____ postal code _____

2. Physician Information

physician's full name _____ area code _____ phone number _____

address _____

city, town, village, etc. _____ province/territory _____ postal code _____

3. Medical Relationship

a) How long have you been treating the patient? _____

b) When did you start treating the patient for the medical condition(s)? _____

c) When did you last examine the patient? _____

4. Medical Assessment

1. a) What medical condition(s) are preventing the patient from working?

_____

_____

b) What was the date of onset? _____

c) Please list all relevant symptoms _____

_____

_____

Personal information on this form is collected under the authority of section 9.2 of the Alberta *Public Sector Pension Plans Act* and section 33 of the Alberta *Freedom of Information and Protection of Privacy Act* for the purpose of determining eligibility for disability pension benefits. If you have any questions regarding the collection of this information, please contact the Member Services Centre (MSC) at 1-877-453-1PSP (1777), or write to PSPP, c/o 5103 Windermere Blvd. SW, Edmonton, AB T6W 0S9.

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2. Detail your findings on examination. Please attach supporting documentation such as reports, x-rays, or other tests.

3. Please list any medication prescribed as a result of the medical condition(s) described in 1(a).

4. Please list any medical history relating to the medical condition(s) described in 1(a).

5. Describe any relevant medical problems other than the medical condition(s) described in 1(a).

6. Describe any activities that worsen the patient's medical condition(s) described in 1(a).

7. a) Do you consider the patient has become incapable of effectively performing the regular duties of his/her work as a result of his/her physical or mental impairment? ❑ yes ❑ no

   b) Do you consider the patient is suffering from a physical or mental impairment that can reasonably be expected to last for the remainder of the patient's lifetime and prevents the patient from engaging in any gainful occupation? ❑ yes ❑ no

8. The duration of the disability is:
   - ❑ Temporary (reasonable probability for recovery)
   - ❑ Permanent (low probability for recovery)

9. Please provide any additional information.

5. Physician Certification

I certify that the information on this form is, to the best of my knowledge and belief, complete and accurate.

physician's signature

date (YYYY/MM/DD)

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