



KP&F-538  
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**Kansas Public Employees Retirement System**  
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[www.kpers.org](http://www.kpers.org)

**Physician's Report of Member's Condition**  
**Please type or print using black ink.**

**Part A - Member Information**

1. Member's Social Security Number: \_\_\_\_\_ 2. Member's Name (Please Print): \_\_\_\_\_
- \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
- First Name Middle Initial Last Name
3. Address: \_\_\_\_\_
4. City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

**Part B - Member Certification**

5. Date sickness or injury caused you to quit work entirely (mo/day/yr): \_\_\_\_\_
6. I hereby authorize any physician who has attended me or who may attend me, or any hospital where I may have been a patient, to disclose any information thus acquired to the Kansas Police & Firemen's Retirement System or its representative, at no expense to the Retirement System. A photocopy of this authorization shall be considered valid as the original.
- Date: \_\_\_\_\_ Member's Signature: \_\_\_\_\_

**Part C - Physician's Statement**

The patient is responsible for the completion of this form without expense to the Kansas Police and Firemen's Retirement System. Disability is defined by the Kansas Police and Firemen's Retirement Act, K.S.A. 74-4952(2) as "the total inability to perform permanently the duties of the position of a policeman or fireman."

**7. History:**

- (a) Date patient became disabled (totally unable to perform the duties of his/her position as a police officer or firefighter): \_\_\_\_\_
- Month Day Year
- (b) Date patient ceased work because of disability: \_\_\_\_\_
- Month Day Year
- (c) Has patient ever had the same or a similar condition?  Yes  No  
If "yes," please state when and describe.

**8. Present Condition:**

- (a) Subjective symptoms:
- (b) Objective findings (include results of current X-rays, E.K.G.'s, or any other special tests):
- (c) Is patient:  Ambulatory  Bed confined  House confined  Hospital confined?

**Part C - Continued**

**9. Diagnosis:**

**10. Treatment:**

(a) Date of First Visit: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (c) Frequency of visits:  Weekly  Monthly  Other

(b) Date of Last Visit: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (d) When did you last examine the patient? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**11. Progress:**  Recovered  Improved  Unimproved  Retrogressed

**12. Mental Condition:**

Is the patient competent to endorse checks and direct the use of the proceeds thereof?  Yes  No

**13. Cause of Disability:**

Was patient's disability a result of an accident or act of duty on the job?  Yes  No

If "yes," please give the date or dates of accident or act of duty: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**14. Extent of Disability:**

(a) Is patient now totally disabled for the duties of his/her current position under the Kansas Police and Firemen's Retirement System?  Yes  No

(b) If "no," when was the patient able to go to work? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

(c) If "yes," when do you think the patient will be able to resume work as a police officer or firefighter?  
Approximate Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Indefinite  Never

**15. Complete this item if the disability is due to cardiac condition.**

(a) Functional capacity (American Heart Association):  Class 1 (no limitation)  Class 3 (marked limitation)  
 Class 2 (slight limitation)  Class 4 (complete limitation)

(b) Blood pressure: \_\_\_\_\_

**16. Remarks:**

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name (Please Print): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

NOTE: K.S.A. 74-4924 provides: "Any person who shall knowingly make any false statement, or who shall falsify or permit to be falsified any record necessary for carrying out the intent of this act for the purpose of committing fraud, shall be subject to the provisions of K.S.A. 21-3904 and amendments thereto."