



# Teachers Retirement Association

60 Empire Drive • Suite 400 • St Paul MN 55103-4000  
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Submit to TRA by mail or FAX (original is not required).

## Medical Examination Report

Member Name		Social Security Number		TRA Number
Address	City	State	Zip	Telephone Number

Please complete this report for use in determining the member's eligibility for disability benefits.

Date of examination:

MM/DD/YYYY

Is this your first examination of our member?  Yes  No

If no, how long has the member been under your care?

Does the member have a physical or mental impairment?  Yes  No

If yes, what is the current diagnosis and history of the impairment? \_\_\_\_\_

\_\_\_\_\_

This impairment is:  improving  static  deteriorating

### Minn. Stat. 354.05, Subd.14.

Total and permanent disability. "Total and permanent disability" means the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to be of long continued and indefinite duration. An "indefinite duration" is a period of at least one year.

1. Is the member **unable** to engage in any substantial gainful activity?  Yes  No

2. Is the impairment of the member expected to last for a period of at least one year?  Yes  No

3. If the answers to 1 and 2 are *yes*, on what date did the total and permanent disability begin? \_\_\_\_\_

Please state your reason(s) for the preceding answers. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This form must be signed by a **licensed physician, chiropractor or psychologist**.

I, the undersigned, a  licensed physician,  chiropractor or  psychologist, certify that the information is complete and accurate to the best of my knowledge.

Printed Name		Telephone	
Signature		Date	
Address	City	State	Zip

