TEACHERS RETIREMENT ASSOCIATION
651.296.2409 800.657.3669 fax 651.297.5999
info@MinnesotaTRA.org

Submit to TRA by mail to 60 Empire Dr., Suite 400, St. Paul, MN 55103, or by fax within 6 months of the date of the exam (original not required)

Medical Examination Report

Member Name	TRA Number
Address	Telephone Number
	Email Address

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

Date of examination (MM/DD/YYYY):

Is this your first examination of the patient? ☐ Yes ☐ No

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

Does the patient 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 patient **unable** to engage in any substantial gainful activity? ☐ Yes ☐ No
2. Is the impairment of the patient 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