BURLINGTON EMPLOYEES' RETIREMENT SYSTEM

PHYSICIAN'S REPORT OF DISABILITY

Date______________, 20__

From:______________________________, M.D.

Address:____

____

To the Retirement Board of the Burlington Employees' Retirement System.

Subject:____
(Member)

____
(Address) (Department)

____

____

This is to certify that M________________________________has been under my

professional care since ____

The subjective and objective symptoms of which the member complains are as follows:

Diagnosis:

Treatment:

Prognosis:

In my opinion, by reason of the above described condition M_______________________
(is) (is not) physically or mentally incapacitated for the further performance of duty and (ought) (ought not) to be retired.

_______________________, M.D.

(over)

Active Number ___________

Dr. ________________________________

____
(Address)

________________________________ Date ________________________________

Dear Doctor:

You are hereby authorized and requested by me to fill out this form and forward it directly to the Retirement Office, 149 Church Street, Burlington, Vermont 05401.

____
(Signature of Member)

____
(Address)

____

____

____

Note: This authorization must be signed by the member and returned to the Retirement Board with the Application for Disability Retirement.