State of Alabama
Unified Judicial System

Form PERS-59 Rev. 4/07

PHYSICIAN'S REPORT OF DISABILITY

(TO BE COMPLETED AND SIGNED BY DOCTOR)

(Please Type)

(APPLICANT: *Do not write on this side; please complete the authorization form on the reverse side.)*

TO: Chief Justice
Alabama Supreme Court
% Alabama Office of Courts
Legal Division
300 Dexter Avenue
Montgomery, AL 36104

SUBJECT: Physician's Report of Disability in the case of:

_____

Sex: ☐ **Male** ☐ **Female**

Date of Birth: _____

Height: _____ **Weight** _____

Blood Pressure: _____ **Urinalysis:** _____

This is to certify that the above named person has been under my professional care for this condition since _____ (Month Day Year) and was last seen on _____ (Month Day Year)

The subjective and objective symptoms of which said person complains are as follows:

CHIEF COMPLAINT AND DURATION: (***In Detail***)

DIAGNOSIS: ***(In Detail)***

PROGNOSIS: ***(In Detail)***

MEDICAL HISTORY:

Give nature and dates of surgical procedure; if any. (Describe fully)

Give nature and dates of other (non-surgical) treatment, if any. (Describe fully)

Is patient still under your care for this condition? If "no", give date your service terminated.

☐ **Yes** ☐ **No**

_____
Month Day Year

Form PERS-59 (back) Rev. 4/07	**PHYSICIAN'S REPORT OF DISABILITY**

DISABILITY DETERMINATION: **In order to qualify for disability retirement, Chapter 18 of Title 12, Code of Alabama 1975, requires that statements must be obtained from three reputable physicians verifying that in their professional medical opinion the above named applicant is "permanently physically and/or mentally unable to carry out the duties of his/her office on a full time basis" and should be retired because of medical disability. If you have made this finding, please expressly indicate by including your statement in the space below.**

REMARKS: ***(Give any information of value not included above.)***

I am a licensed physician in the State of _____ Date _____
Specialty _____ **Board Certified?** _____

I graduated from _____
Medical School located in _____ Year _____

Are you related to the patient by blood or marriage? If "yes" state relationship. _____

This report must be signed personally by physician.

Sworn to and subscribed before me this

Date: _____

_____
Notary Public

_____
Signature

_____
Name

_____
Street Address

_____
City **State** **Zip**

_____
Telephone Number

NOTE: Section 36-27-27, Code of Alabama 1975, states: Any person who makes a false statement or falsifies a record in any attempt to defraud the Retirement Systems shall be guilty of a misdemeanor, and upon conviction, be punished by fine up to $500.00 and/or imprisonment not to exceed one year.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(To be Completed and Signed by Applicant)

TO: Dr. _____

_____
Street Address

_____
City **Sate** **Zip**

DATE: _____
Month **Day** **Year**

Dear Doctor:

You are hereby authorized and requested by me to complete the form on the reverse side of this sheet, have it notarized and forward it along with supporting documentation to the Administrative Office of Courts.

_____
Name of Applicant

_____
Title

_____
Social Security Number

_____
Signature of Applicant

_____
Street Address

_____
City **State** **Zip**