TEACHERS' PENSION PLAN CORPORATION
NEWFOUNDLAND & LABRADOR

ASSESSMENT FOR MEDICAL DISABILITY PENSION

Please complete this form and return it to the Teachers' Pension Plan Corporation along with any supporting documents that the physician feels necessary to support disability.

Section I – MEMBER INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL INSURANCE NUMBER	HOME MAILING ADDRESS	
DATE OF BIRTH		
MCP #	PHONE NUMBER	

Section II – MEMBER CONSENT

A pre-requisite for medical retirement is that the plan member is unable to perform efficiently the duties of the employment in which he or she was engaged before the commencement of the impairment provided that the impairment is medically certified to the satisfaction of the Administrator as likely to be permanent.

I hereby authorize the release of the medical information as requested herein for the purpose of determining my eligibility for retirement on medical grounds.

MEMBER SIGNATURE	DATE SIGNED

NOTE TO PHYSICIANS:

Please be thorough when completing this form as it will be used to determine whether the applicant qualifies for a lifetime dependent survivor pension.

140 Kelsey Drive, Suite 300, St. John's, NL, Canada A1B 0T2
Tel 709-793-8772 1-833-345-8772
www.tppcnl.ca

Section III – MEDICAL INFORMATION – TO BE FILLED OUT BY PHYSICIAN

1. DIAGNOSES (in order of significance)

A. _____ B. _____

C. _____ D. _____

OBJECTIVE FINDINGS (including results of x-rays, laboratory reports or any other special tests):

_____

_____

_____

_____

2. HISTORY

A. When did symptoms first appear, or accident occur? _____

B. Date total disability commenced? _____

C. Is disability due to injury or sickness resulting from the applicant's employment? _____

3. TREATMENT

A. Date of first visit? _____

B. Date of latest visit? _____

C. Is the applicant following a recommended treatment program? ☐ YES ☐ NO

4. PHYSICAL IMPAIRMENT

Is Applicant: ☐ House confined ☐ Bed confined ☐ Hospital confined ☐ Other

Are there any other contributing factors to the applicant's disability, e.g. obesity, substance abuse? ☐ YES ☐ NO

Please Explain: _____

_____

_____

_____

_____

_____

5. EFFECT OF MEDICAL CONDITION ON PERFORMANCE DUTIES

Please explain the extent to which the applicant's disability affects his/her capacity to perform his/her regular duties:

6. PROGNOSIS

A. Does disability prevent the applicant from ever performing the duties of his/her regular occupation? ☐ YES ☐ NO

B. If no, please indicate when you would expect the applicant to recover sufficiently to perform duties on a total or partial basis?

C. If "yes" please indicate date of total disability:

7. REHABILITATION

Regular Occupation

A. Is the applicant a suitable candidate for trial employment? ☐ YES ☐ NO

B. If yes; when could trial employment commence? FULL TIME

PART TIME

C. If "no" please explain

D. Would vocational counseling and/or training be recommended? ☐ YES ☐ NO

8. ADDITIONAL COMMENTS

Briefly state in 'lay persons' terms why you feel this applicant's prolonged disability prevents him/her from regularly pursuing any substantially gainful employment.

Section IV – PHYSICIAN INFORMATION

PHYSICIAN NAME	OFFICE MAILING ADDRESS
OFFICE PHONE NUMBER	
PHYSICIAN SIGNATURE	DATE SIGNED