Reset Form

ATTENDING PHYSICIAN'S STATEMENT FOR A CLASSROOM DISABILITY BENEFIT

State Form 17296 (R8 / 9-23)

INDIANA PUBLIC RETIREMENT SYSTEM
TEACHERS' RETIREMENT FUND
One North Capitol Avenue, Suite 001
Indianapolis, IN 46204-2014
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INSTRUCTIONS

1. This form must be delivered by the applicant to the member's attending physician.
2. This form must be completed, signed, and dated by the member's attending physician and mailed by the attending physician to the Fund physician. In compliance with Health Information Portability and Accountability Act (HIPAA) regulations, this form cannot be faxed or e-mailed because of the personal health information (PHI) contained in the document.
3. The applicant must make any payments necessary to complete this statement.
4. This statement must be filed before a disability application will be considered.

This form is required as part of the application for a Classroom Disability benefit and is required for the annual review of the member's continued eligibility for the Classroom Disability benefit. The process for initiating or continuing a Classroom Disability benefit is as follows:

1. The *Attending Physician's Statement for a Classroom Disability Benefit (State Form 17296)* must be completed by the member's personal physician.
2. After completion, the *Attending Physician's Statement for a Classroom Disability Benefit (State Form 17296)* must be sent by the member's attending physician directly to the Fund physician (appointed by the Indiana Public Retirement System (INPRS) Board of Trustees and named in the cover letter sent with this form).
3. The Fund physician appointed by INPRS reviews the completed *Attending Physician's Statement for a Classroom Disability Benefit* (State Form 17296) and makes a determination as to the member's eligibility or continued eligibility for a Classroom Disability benefit.
4. The Fund physician reports the determination of eligibility or continued eligibility for the Classroom Disability benefit to the Fund.
5. INPRS notifies the member of the member's eligibility for a classroom disability benefit or of continued eligibility based on the recommendation of the Fund physician.
6. If the *Attending Physician's Statement for a Classroom Disability Benefit (State Form 17296)* is being requested as part of the annual review for continuation of the Classroom Disability benefit, the final determination from the Fund physician must be received by INPRS within sixty (60) days. If the final determination is not received within the required sixty (60) days, the member's Classroom Disability benefit is to be suspended until the final determination is received

GENERAL INFORMATION

IC 5-10.4-5-1(b) A member who is an active teacher, has earned at least five (5) service credits, and suffers a temporary or permanent disability that continues for at least six (6) months may receive a classroom disability benefit for as long as the disability exists.

35 IAC 14-1-4 A classroom disability refers to a medically confirmed inability to continue classroom teaching due to a mental or physical condition that is not necessarily of sufficient severity to meet Social Security disability guidelines.

35 IAC 14-9-1 (c) A member's continuing eligibility for classroom disability benefits shall be reviewed on an annual basis.

If, with reasonable accommodations made by the employer, the member is able to perform the essential elements of the member's job, the member is not considered to be disabled from teaching and therefore does not qualify for a Classroom Disability benefit. As an example, the inability to drive to and from work is not justification for a disability determination if the member can otherwise perform the necessary teaching functions.

MEMBER INFORMATION

Member's name	Pension ID (PID)number	Date of birth (*mm/dd/yyyy*)

Address *(number and street)*	Telephone number with area code	

City	State	ZIP Code

MEMBER AUTHORIZATION

I hereby make initial/renewal application for Classroom Disability benefits under the provisions of *IC 5-10.4-5-1(b)*.
I hereby authorize my physician to release such medical records as are necessary for this determination to the board-approved reviewing physician.

Member's signature	Date *(mm/dd/yyyy)*

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Member's name	Pension ID (PID)number	Date of birth (*mm/dd/yyyy*)

PATIENT HISTORY

This section must be completed by the attending physician in the handwriting of the attending physician and mailed by him/her to the Indiana Public Retirement System Board of Trustees' physician for review.

How long have you been the physician for the patient?	Date of your first visit with the patient for illness claimed to have brought about the present condition (*mm/dd/yyyy*).

Number of visits	Date of last visit (*mm/dd/yyyy*)	Patient's height in inches	Patient's weight in pounds	Patient's blood pressure

What organ, system or parts of the body have been affected?

Describe fully the course of the disease, its initial symptoms and the history of its progress.

Has the patient suffered from any ailments other than those mentioned above? ☐ Yes ☐ No
If Yes, describe each case and state the duration of the ailment and if recovery was complete.

Has the patient been attended to or prescribed for any other physician or surgeon within three (3) years? ☐ Yes ☐ No
If Yes, for what reason? Provide the names and addresses of all such physicians and surgeons.

Is the patient wholly and continuously unable to perform the work of a public school teacher? ☐ Yes ☐ No
If Yes, is the disability, in your opinion, likely to be temporary, permanent and total, or permanent and partial?

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Member's name	Pension ID (PID)number	Date of birth (*mm/dd/yyyy*)
List specific reasons why you consider the patient to be unable to perform the work of a public school teacher.		

ATTENDING PHYSICIAN INFORMATION		
Attending physician's name		
Address *(number and street)*	Telephone number with area code	
City	State	ZIP Code
How long have you been a practicing physician?	Where did you receive your medical education?	
Attending physician's signature	Date *(mm/dd/yyyy)*	
Upon completion, including the attending physician's signature, date signed, and printed name and address, forward this document to the physician appointed by the Indiana Public Retirement System Board of Trustees. The physician's name and address are included in the cover letter accompanying this form.		