Physician and Treating Facility History

Form DSBL 5 – Revised 04/06/2015

Please print or type in black ink. Mail or fax completed form(s) to PERS. See bottom of form for contact information.

❶ **Member Information** – *To be completed by the member or an authorized representative of the member.*

First Name: ______________________ MI: ______ Last Name: ______________________

Social Security No.: ______________________ Birth Date *mm/dd/ccyy*: ______________________

❷ **Treating Physician Information** – *List physicians who treated you in the last five years for the medical condition claimed. Attach additional sheet, if needed.*

1. Physician's Name: ______________________ Medical Specialty (e.g., cardiology, psychiatry, etc.): ______________________

Mailing Address: ______________________ City: ______________________ State: ________ Zip: ______________

Phone: ______________________ Frequency of Visits (e.g., daily, weekly, monthly, etc.): ______________________

Date First Seen *mm/dd/ccyy*: ______________________ Date Last Seen *mm/dd/ccyy*: ______________________

Reason for Visits/Treatments: ______________________

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2. Physician's Name: ______________________ Medical Specialty (e.g., cardiology, psychiatry, etc.): ______________________

Mailing Address: ______________________ City: ______________________ State: ________ Zip: ______________

Phone: ______________________ Frequency of Visits (e.g., daily, weekly, monthly, etc.): ______________________

Date First Seen *mm/dd/ccyy*: ______________________ Date Last Seen *mm/dd/ccyy*: ______________________

Reason for Visits/Treatments: ______________________

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3. Physician's Name: ______________________ Medical Specialty (e.g., cardiology, psychiatry, etc.): ______________________

Mailing Address: ______________________ City: ______________________ State: ________ Zip: ______________

Phone: ______________________ Frequency of Visits (e.g., daily, weekly, monthly, etc.): ______________________

Date First Seen *mm/dd/ccyy*: ______________________ Date Last Seen *mm/dd/ccyy*: ______________________

Reason for Visits/Treatments: ______________________

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4. Physician's Name: ______________________ Medical Specialty (e.g., cardiology, psychiatry, etc.): ______________________

Mailing Address: ______________________ City: ______________________ State: ________ Zip: ______________

Phone: ______________________ Frequency of Visits (e.g., daily, weekly, monthly, etc.): ______________________

Date First Seen *mm/dd/ccyy*: ______________________ Date Last Seen *mm/dd/ccyy*: ______________________

Reason for Visits/Treatments: ______________________

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❸ **Treating Facility Information** – *List facilities in which you were treated in the last five years for the medical condition claimed. Attach additional sheet, if needed.*

1. Treating Facility Name: ______________________ ☐ Inpatient ☐ Outpatient ☐ Emergency

Mailing Address: ______________________ City: ______________________ State: ________ Zip: ______________

Admission Date *mm/dd/ccyy*: ______________________ Discharge Date *mm/dd/ccyy*: ______________________

Reason for visit and treatment (List any special testing including x-rays, MRIs, etc.): ______________________

2. Treating Facility Name: ______________________ ☐ Inpatient ☐ Outpatient ☐ Emergency

Mailing Address: ______________________ City: ______________________ State: ________ Zip: ______________

Admission Date *mm/dd/ccyy*: ______________________ Discharge Date *mm/dd/ccyy*: ______________________

Reason for visit and treatment (List any special testing including x-rays, MRIs, etc.): ______________________

❹ **Applicant Certification** – I understand that any person who makes a false statement or shall falsify or permit to be falsified any record of a retirement plan administered by PERS in an attempt to defraud the plan may be subject to criminal prosecution. With that understanding, I certify that all of the preceding information is true and complete to the best of my knowledge. *If an authorized representative signs this form, attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.*

Applicant Signature: ______________________ Date *mm/dd/ccyy*: ______________________