# 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: _____

_____

**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: _____

_____

**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: _____

_____

**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: _____

_____

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:* _____

Public Employees' Retirement System of Mississippi
429 Mississippi Street, Jackson, MS 39201-1005 800.444.7377 601.359.3589 601.359.1024, *fax* www.pers.ms.gov

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