GOVERNMENT EMPLOYEES RETIREMENT SYSTEM
3438 Kronprindsens Gade, GERS Complex - Ste. 1, St. Thomas, VI 00802-5750 • (340) 776-7703 • Fax (340) 776-4499
3005 Orange Grove, Lot 5, Christiansted, St. Croix, VI 00820-4313 • (340) 773-5480 • Fax (340) 773-5497
www.usvigers.com

PHYSICIAN'S GUIDELINES

DUTY DISABILITY (Title 3 V. I. Code, Section 708)

(a) Any member who becomes totally and permanently incapacitated for service as the proximate result of bodily injuries sustained or a hazard undergone while in the performance and within the scope of his duties, if such injuries or hazard were not the consequences of the willful negligence of the member; shall receive a duty disability annuity; provided, that application is made not more than six months after the date of the accident if an accidental disability, or six months after the occurrence of disablement, if an occupational disease and proper proof is received from one or more physicians designated by the Board that such member is mentally or physically incapacitated;

Or the application shall be made not more than six months after the date the member has been advised that he/she is permanently and totally incapacitated for service, if an accidental disability, or six months after the occurrence of disablement if an occupational disease and proper proof is received from one or more physicians designated by the Board that such member is mentally or physically incapacitated.

NON-DUTY DISABILITY (Title 3 V. I. Code, Section 710)

(a) Any member under age 60 having at least 9 years of credited service who becomes totally and permanently disabled for service, either mentally or physically, from any cause other than duty disability shall be entitled to a non-duty disability annuity.

(c) A member shall be considered totally and permanently disabled only after the board has received (1) written certification by at least two licensed and practicing physicians, selected by the Board, that the member is totally and likely to be permanently disabled for further performance of the duties of any assigned position in the service of the employer; and (2) written certification from the employer that the member has been separated from the service of the employer because of a total and permanent disability of such nature as to reasonably prevent further service for the employer, and as a consequence is not entitled to compensation from the employer.

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PHYSICIAN'S MEDICAL REPORT

Name of Applicant (Print) _____
(Last) (First) (Middle)

Applicant's Social Security _____

Mailing Address _____

_____

THE ABOVE-NAMED APPLICANT IS REQUESTING A DISABILITY ANNUITY UNDER THE EMPLOYEES' RETIREMENT SYSTEM OF THE GOVERNMENT OF THE VIRGIN ISLANDS.

SECTION A - Diagnosis:

a) I, _____ M.D., certify that I examined the above-named applicant at _____.
(Name of Facility)

b) The applicant's disability is a _____Non-Duty Disability _____Duty Disability.

c) When did you first treat this patient? Date: _____

d) Date of most recent examination: _____

e) Primary disabling condition: _____

_____

f) Secondary condition(s): _____

_____

g) What restrictions have you placed on the patient's activities? _____

_____

SECTION B – Prognosis:

a) Has the patient's condition stabilized? Yes _____ No _____

b) Has the patient reached maximum medical improvement? Yes _____ No _____

c) If so, when did the patient reach maximum medical improvement? Date _____

d) Is the patient a candidate for vocational rehabilitation? Yes _____ No _____

e) Additional Comments: _____

_____

_____

SECTION C - Physical and/or Medical Impairment:

_____ No limitation of functional capacity; may return to work.

_____ Slight limitation of functional capacity; capable of light work.

_____ Moderate limitation of functional capacity; capable of sedentary work.

_____ Cannot perform present work, but capable of performing another line of work.

_____ Temporary limitation of functional capacity; temporarily incapable of any kind of work; temporarily disabled from gainful employment.

_____ Severe limitation of functional capacity; permanently incapable of any kind of work; totally and permanently disabled from gainful employment.

SECTION D - In-Line-Of-Duty:

(Complete only if in-line-of-duty disability retirement arose out of the performance of duty. All four questions must be answered.)

a) Is the patient's primary disability due to an on-the-job injury or illness? _____

_____

b) If so, what was the date of the injury? _____

c) How do you relate the primary disability to the on-the-job injury? _____

_____

d) Is there any cause other than the on-the-job injury contributing to the patient's disability? Yes____ No_____.

If yes, please explain_____

Additional Comments: _____

_____

SECTION E - Findings:

My opinion is based on the following summary of physical findings and laboratory reports as of _____.
(Date)

Physical Findings: _____

Laboratory Report: _____

Five-year Medical History: _____

Current Treatment: _____

Assessment:_____

_____

_____

SECTION E - Conclusion:

No person shall be retired for disability except upon the written report to the Board of Trustees from a licensed physician. The Physician's Medical Report shall describe the origin and history of the disability, its prognosis and such other information as the physician may deem pertinent. This report shall contain the opinion of the physician in these exact words:

- It is my opinion that _____has become permanently and totally disabled from engaging in any gainful employment in his/her assigned position in the service of the government or in any similar capacity.
- It is my opinion that _____has NOT become permanently and totally disabled from engaging in any gainful employment in his/her assigned position in the service of the government or in any similar capacity.

If the applicant is not totally and permanently disabled, will he/she be able to perform the duties of his/her position?

Yes_____No_____

If yes, indicate when applicant might be expected to return to active duty_____

_____.

I, _____a practicing physician duly registered as such under the laws of

_____,

my registry number being _____do hereby certify that my answers to the foregoing questions are complete and true to the best of my knowledge, information and belief.

Date_____

Signed_____ M.D.
(Name of Physician)

_____
(Address)

_____
(City, State)

Telephone No. _____