



Please print or type in black ink.  
Please do not staple pages.

**Section A. Tell us about yourself, the patient/disability applicant.**

FIRST NAME	MI	LAST NAME	SUFFIX	AGE	DATE OF BIRTH
MAILING ADDRESS					SSN (Last 4 digits)
CITY	STATE	ZIP CODE	TELEPHONE NO.		MEMBER ID
E-MAIL ADDRESS					<b>RSD USE ONLY</b>  DATE OF RE-EXAM
JOB TITLE					

**Section B. Please check the retirement system and benefit if applicable.**

- |   |   |
|---|---|
| <input type="checkbox"/> Teachers' and State Employees' Retirement System (TSERS) | <input type="checkbox"/> Legislative Retirement System (LRS)            |
| <input type="checkbox"/> Local Governmental Employees' Retirement System (LGERS)  | <input type="checkbox"/> Consolidated Judicial Retirement System (CJRS) |

**Section C. TO BE COMPLETED BY A LICENSED PHYSICIAN:**

**INSTRUCTIONS TO THE LICENSED PHYSICIAN**

This form is intended to help in the determination of a member's disability.

**Provide documentation supporting your diagnosis such as you would if another licensed physician were reviewing the patient's case, including but not limited to:**

- Surgical, diagnostic, and lab reports
- CAT/MRI scans or other radiology reports (no films or images accepted)
- Examination notes
- Hospitalization records
- Other specialized test results supporting your diagnoses

1 Indicate your type of practice or medical specialty: \_\_\_\_\_

2	Diagnosis (Full Name <b>Required</b> )	Date of Onset (Required)	ICD-10 Code (Required)
	Primary		
	Contributing		
	Contributing		
	Contributing		

3 When did the patient become disabled? (mm-dd-yyyy)

**Please continue to the next page.**



4 Date of the patient's most recent visit? (Must be within the past six months)

5 Date your practice first saw the patient:

6 Does the patient's disability cause him or her to be **permanently or temporarily** incapacitated from the performance of his or her usual occupation?  permanently  temporarily

6a If **temporary**, what is the estimated recovery date? (MM/DD/YYYY)  
(Give the approximate date the patient will be able to return to work.)

7 In the space below explain:

- How the disability impacts the patient's normal work activity; and
- Any other restrictions or limitations to the patient's activities.

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8 Given your observations about the patient, can he or she perform *any* work?

Sedentary  Light  Medium  Heavy  None

9 What is the patient's: Weight  Height  Blood Pressure

10 List all surgical procedures related to the disability. **Attach all reports and documentation regarding each procedure.**

Procedure	Date	Patient Response

11 List all current medications the patient has been prescribed. If there is not enough room provided, please attach a list.

Medication	Dosage	Duration

**Please continue to the next page.**

MEMBER LAST NAME	MEMBER SSN (Last 4 digits)
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12 Describe any other treatment or therapy.

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**Section D. Licensed Physician, please tell us about your practice and sign this form.**

NAME OF LICENSED PHYSICIAN'S PRACTICE, IF APPLICABLE				
LICENSED PHYSICIAN'S FIRST NAME	MI	LAST NAME	TITLE	LICENSE NO.
MAILING ADDRESS				<b>DO NOT SEND A BILL TO THE RETIREMENT SYSTEM</b>
CITY	STATE	ZIP CODE	TELEPHONE NO.	

Unless otherwise specified, the Retirement System **will not** assume any responsibility for payment of fees for furnishing the requested information.

Licensed Physician's Signature \_\_\_\_\_ **STAMP NOT ACCEPTED** \_\_\_\_\_ Date \_\_\_\_\_

**Section E. Please submit this form by mail or fax.**

You may mail this form to the address below, or fax to (919) 855-5800.

**Thank you.**

*N.C. Department of State Treasurer, Retirement Systems Division  
3200 Atlantic Avenue, Raleigh, North Carolina 27604  
1-877-NCSECURE (1-877-627-3287) toll-free  
www.myncretirement.com*

MEMBER LAST NAME	MEMBER SSN (Last 4 digits)
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REV 20180817

**7AR**

### Guide A. What is the purpose of the Form 7AR?

The Form 7AR provides the Medical Board with a licensed physician's detailed diagnosis of your disability. The Medical Board is a panel of licensed physicians who review the Form 7AR. They also review supporting medical information to certify that your illness or condition allows you to be eligible for a disability benefit.

Your disability must:

- occur **while you are actively contributing** to a North Carolina retirement system;
- incapacitate you from the performance of your **usual occupation**; and
- be determined by a licensed physician.

After the Medical Board has reviewed your form, we will notify you by mail of the decision:

- **If your application is approved**, you will receive a letter providing you with the additional steps you must take so that we can process your disability benefit.
- **Your application may be rejected** for one of the following reasons:

1. The Medical Board may request additional information. You will have 90 days to return to your physician, request additional information, and submit it to the Retirement Systems Division;  
**or**
2. The Medical Board has determined that you are not disabled.

### Guide B. What am I responsible for?

- You must have visited the licensed physician who signed your Form 7AR **within the past six months**.

- You are responsible for your medical bills. The Retirement Systems Division is not responsible for any payment of fees to the physicians providing medical information.

### Guide C. What is my health care professional responsible for?

- A licensed physician must fill out the Form 7AR **completely**.
  - The form is designed to allow a licensed physician to provide all medical documentation supporting your diagnosis so the Medical Board can review your application.

- A licensed physician should fully document and explain how your disability impairs your ability to perform your usual occupation.
- A licensed physician will determine if you are capable of performing any other type of work besides your usual occupation and to what degree you may be able to perform work.

**These guides are subject to and governed by the General Statutes of the State of North Carolina.**