North Carolina
Total Retirement Plans

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

Form **7AR**
Medical Report for Disability Re-Examination

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	**RSD USE ONLY**
	DATE OF RE-EXAM
JOB TITLE	

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

- ☐ Teachers' and State Employees' Retirement System (TSERS)
- ☐ Local Governmental Employees' Retirement System (LGERS)
- ☐ Legislative Retirement System (LRS)
- ☐ 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 **Required**)		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.

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.

12 Describe any other treatment or therapy.

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				**DO NOT SEND A BILL TO THE RETIREMENT SYSTEM**
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)

North Carolina
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Form **7AR Guides**
Medical Report for Disability Re-Examination

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.

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