

Please print clearly in black ink.

Section 1: Annual Medical Update

For Members Receiving a Disability Retirement Allowance

Please take this page with you to one of your doctor's appointments during 2024.

Name of Member

Member Date of Birth (mm/dd/yyyy)

Doctor's Name

Date of Examination (mm/dd/yyyy)

Section 2: To Be Completed By Your Doctor (Due by December 31, 2024)

Please provide a response to the following statement based on your medical opinion.

The Member likely remains unable to work in the position from which he or she retired.

- Yes Further independent examination is recommended to determine.

Please attach a copy of the Member's current medical report.

Additional Notes (optional):

Section 3: Doctor's Signature

Doctor's Signature

Date of Signature (mm/dd/yyyy)

This box is only applicable for Members who are unable to see a doctor during 2024. Member, please check the reason below and return to ERSRI.

- I cannot afford to see a doctor. I do not have a doctor. My doctor will not sign the form.

Other (please explain): _____

Return the completed form to the address below. Incomplete or inaccurate forms will not be processed.

Employees' Retirement System of Rhode Island

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