United States
Office of Personnel Management
Disability, Reconsideration, & Appeals Group
1900 E Street NW - Room 3468
Washington DC 20415-3551

Form Approved:
OMB No. 3206-0143

Date (mm/dd/yyyy)
Claim number **CSA**
Date of birth *(mm/dd/yyyy)*

This Questionnaire Must Be Returned Within 90 Days for Your Disability Annuity to Continue

You were approved for disability retirement on the basis of the documentation you provided. The retirement system requires a periodic check of disability annuitants to determine if the condition on which they retired continues to be disabling. The information listed below is needed to comply with that requirement. The Office of Personnel Management (OPM) will not pay for any expenses that you may incur in acquiring this documentation.

In order for us to evaluate whether or not you are entitled to continuation of disability annuity payments, please have your physician or treating medical facility provide the following information:

1. Current clinical findings from a recent physical examination, including the results of any diagnostic tests that have been performed.
2. An update since your retirement of the specific medical condition(s) which required you to retire. This should include a current diagnosis.
3. An assessment, including a current prognosis, of the specific medical condition(s) and plans for future treatment.
4. A clinical assessment of risk of injury or hazard to self and others which would arise from the performance of essential duties of a position similar to the one from which you retired.

Also, answer the questions on the reverse side of this form, sign Item 4 and mail the documentation to the above address. If the information shows that you are still disabled for your former position, your annuity will be continued without further correspondence from us. If our review requires additional information, you will be notified.

If we do not receive this questionnaire and the requested medical documentation within 90 days, we may suspend your annuity payments until the requested information is received. If you are unable to respond within the time limitation or if we can be of further assistance to you, please contact the Disability Section at (202) 606-0280/0290.

Retirement Services Program

Important: Answer all questions and return promptly

1. Have you recovered sufficiently to return to work? ☐ Yes ☐ No

2. Are you now employed, or have you been employed during the last 12 months (including self-employment)? If **yes**, state below: ☐ Yes ☐ No

Dates of Employment		Hours Per Day	Total Earnings	Name and Address of Employer *(including ZIP code)*
From *(mm/dd/yyyy)*	To *(mm/dd/yyyy)*			

State type of position and nature of duties *(attach a copy of position description if available).*

Inquiry may be made of your present employer to verify your records of employment and medical condition.

Name of immediate supervisor	Telephone number *(including area code)*

3. Have you ever received or made application for compensation from the U.S. Department of Labor, Office of Workers' Compensation Programs, under the Federal Employee's Compensation Act? ☐ Yes ☐ No

*If **yes**, state your Compensation claim number and the period(s) for which you received compensation.*

Compensation claim number	From *(mm/dd/yyyy)*	To *(mm/dd/yyyy)*

Warning: Any intentionally false statement or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 USC 1001)

4. **I hereby affirm that the above answers are true to the best of my knowledge and belief.**

Signature		Mailing address *(including ZIP code)*
Date *(mm/dd/yyyy)*	Telephone number *(including area code)*	

Privacy Act and Public Burden Statements

Title 5, U.S. Code, authorizes solicitation of this information. The data you furnish will be used to determine whether your disability annuity can continue. This information may be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local or other charitable or social security administrative agencies to determine and issue benefits under their programs, to obtain information necessary for determination or continuation of benefits under this program, or to report income for tax purposes. It may also be shared and verified, as noted above, with law enforcement agencies when they are investigating a violation or potential violation of civil or criminal law. Providing this information is voluntary; however, failure to supply all of the requested information will result in a suspension of your disability annuity.

We think this form takes an average 60 minutes per response to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management (OPM), Reports and Forms Coordinator (3206-0143), Washington, DC 20415-7900. The OMB Number 3206-0143 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number displayed.