Form Approved:
OMB Number 3206-0179

United States
Office of Personnel Management
Retirement Operations Center
PO Box 45
Boyers, PA 16017-0045

Disabled Dependent Questionnaire

1. Name of disabled dependent *(last, first, middle)*	2. Dependent's date of birth *(mm/dd/yyyy)*
3. Name of annuitant or deceased annuitant *(last, first, middle)*	4. Claim number **CS**

Complete Part A below and ask the physician to complete Part B on the other side of this form.

Part A. To Be Completed by Disabled Dependent or Dependent's Guardian or Other Fiduciary

1a. The disabled dependent is:

- ☐ not married and lives:
  - ☐ with parent(s)
  - ☐ with guardian or other fiduciary
  - ☐ none of the above (explain below)
- ☐ married (if married, skip to item 6 and return this form to us.)

1b. Please provide the disabled dependent's address and the name of the person he or she lives with.

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2. Is there a court appointed guardian or other fiduciary to handle the affairs of the disabled dependent?

☐ Yes → Attach a copy of the court order. ☐ No

3. Has the disabled dependent been employed during the last twelve months?

☐ Yes ☐ No → Go to question 5.

4a. Periods and type of employment:

From *(mm/dd/yyyy)*	To *(mm/dd/yyyy)*	Description of work performed

4b. Total earnings during periods of employment listed in 4a:

$

4c. Was employment in a closely supervised environment, e.g., closed workshop?

☐ Yes ☐ No

5. Highest level of education of disabled dependent:

6. Certification

I certify that the above statements are true to the best of my knowledge and belief. I hereby authorize the release of medical evidence and information to the Office of Personnel Management (OPM).

Signature of disabled dependent, guardian, or other fiduciary	Telephone number ( )	Field added for email address	Date *(mm/dd/yyyy)*

Please have the disabled dependent's physician complete the back of this form and return the completed form to the above address.

Part B. To Be Completed by the Physician

In order to determine if your patient is eligible for benefits under the retirement law, we need information regarding the patient's current medical condition.

1. Diagnosis of disability:

2. Estimate of the expected date of full or partial recovery:	3. Age at onset:	4. Severity of disability: ☐ Mild ☐ Moderate ☐ Severe	5. If patient is mentally retarded, state approximate mental age:	6. If patient is mentally retarded, give results of IQ tests:

In addition, please attach a narrative (on your letterhead stationery) addressing the following points:

1. The history of the specific medical condition(s), including references to findings from previous examinations, treatment, and responses to treatment.
2. Clinical findings from your most recent medical evaluation, including findings of physical examinations, results of laboratory tests, X-rays, EKG's and other special evaluations or diagnostic procedures and, in the case of psychiatric disease, the findings of mental status examinations and the results of psychological tests.
3. Assessment of the current clinical status and plans for future treatment.
4. Assessment of the degree to which the medical condition has or has not become static, well stabilized, or controlled, and an explanation of the medical basis for the conclusion.
5. Specify the physical and/or mental limitations or restrictions caused by the patient's medical condition(s).
6. Does the patient's condition preclude or limit self-supporting employment? Explain your answer.
7. If the patient is incapable of self-support, at what age did the patient become incapable?
8. Can the patient handle his or her own finances?

Signature	Print or type name	Date

Address	Telephone number *(including area code)*

Return the completed form and the narrative to the address on the front of the form.

Public Burden Statement

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), OPM Forms Officer (3206-0179), Washington, DC 20415-7900 The OMB Number, 3206-0179 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

Privacy Act Statement

Title 5, U.S. Code, Chapters 83 and 89, authorize solicitation of this information. The data you furnish will be used to determine whether the disabled dependent is eligible for continued benefits. 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 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. Provision of this information is voluntary; however, failure to supply all of the requested information may result in our inability to allow benefits.