United States of America
Railroad Retirement Board

PROPOSED

Form Approved
OMB No. 3220-0038

Report of Seizure Disorder

Section 1 Information for the Medical Examiner

An application for Railroad Retirement Act benefits based on disability for work has been filed. Information about the applicant's medical condition is essential to evaluate benefit eligibility. If you need more space than is provided to answer a question, use Item 21 for this purpose.

Since applicants are responsible for presenting medical evidence on their own behalf from their personal physicians, any fee that may result from completion of this report is a personal matter between the applicant and you (unless we specifically contract for an examination).

Please complete and return this report promptly to the address shown in Item 26. Your report may be made on this form or by a narrative on your own stationery. It is important that your narrative furnish all of the information, relevant to the applicant's condition, requested on this form.

Section 2 Instructions

Print all answers in ink or use a typewriter. When entering dates, always use numbers. Also, be sure there is one number in each box. For example, you would enter February 13, 2014, as:

MONTH	DAY	YEAR
0 2	1 3	1 4

Based on your answer to a question, you may be told to skip to another item number. Follow the instructions that tell you to "Go to" another item. These are designed to save you time and help you move through the report form quickly, filling in only necessary information. **If no "Go to" instructions are given, answer the next item in order. Do not skip any items unless directed to do so.** Please read "Important Notices" on the last page of this report.

Section 3 Identifying Information

1	RAILROAD RETIREMENT CLAIM NUMBER →		
2	SOCIAL SECURITY NUMBER →		
3	APPLICANT'S NAME →		
4	a STREET ADDRESS →		
	b CITY AND STATE →		
	c ZIP CODE →		
	d COUNTY →		
5	DAYTIME TELEPHONE NUMBER →		See Attachment - #1

Section 4 Introduction

6 Enter a detailed description of the seizures (include character, generalized or focal; aura, if any; loss of consciousness; bowel or bladder incontinence).

Section 5 Types of Seizure

7	a	Check the appropriate description. ⟶	❑ Grand Mal ❑ Petit Mal ❑ Jacksonian ❑ Psychomotor
	b	Check the appropriate description. ⟶	❑ Nocturnal ❑ Diurnal

Section 6 History of Seizures

8	Enter the date of the first seizure. ⟶	MONTH	DAY	YEAR		
9	Enter the date of the last seizure. ⟶	MONTH	DAY	YEAR		
10	a	Enter the approximate dates of seizures in the past year. ⟶				
	b	Explain how this is known.				
	c	Enter an "X" in the appropriate box: Does verification of seizures exist from persons other than applicant? ⟶	❑ YES ▶ **Go to Item d** ❑ NO ▶ **Go to Item 11**			
	d	Describe the verification and identify the source.				

Section 7 Precipitating Factors

11	a	Enter an "X" in the appropriate box: Are there any precipitating factors? ⟶	❑ YES ▶ **Go to Item b** ❑ NO ▶ **Go to Item 12**
	b	Describe the precipitating factors.	

Section 8 Duration of Seizures

12	Describe the duration of the seizures.	

Section 9 Treatment

13	a	Enter an "X" in the appropriate box: Has any treatment been given for this condition? ⟶	☐ YES ▶ **Go to Item b** ☐ NO ▶ **Go to Item 14**
	b	Describe the type of treatment given.	
	c	Describe the applicant's compliance to such treatment.	
	d	Describe the applicant's response to such treatment.	
	e	Describe the applicant's blood drug level.	

Section 10 Mental Functions

14	a	Enter an "X" in the appropriate box: Has there been any mental deterioration? ⟶	☐ YES ▶ **Go to Item b** ☐ NO ▶ **Go to Item 15**
	b	Describe the deterioration.	

15	a	Enter an "X" in the appropriate box: Is there evidence of any psychosis? ⟶	☐ YES ▶ **Go to Item b** ☐ NO ▶ **Go to Item 16**
	b	Describe the psychosis.	
16		Describe behavior manifestations (postictal) and duration.	

Section 11 Neurological Findings

17	Describe the neurological findings.

Section 12 Electroencephalographic Findings

18	Describe the EEG findings, and attach a copy of the EEG (or identify the source from which it may be obtained).

Section 13 Miscellaneous

19	Enter an "X" in the appropriate box: This report is: a. Compiled entirely from records → b. Based on a new examination →	YES ❑ ❑		
20	Enter the date of the most recent examination. →	MONTH	DAY	YEAR

Section 14 Remarks

21 Use this space for further details of history or additional description of condition.

Section 15 Certification

See Attachment #2

22	Medical Examiner's Name →		
23	a Street Address →		
	b City and State →		
	c ZIP Code →		
24	Daytime Telephone Number →	AREA CODE	TELEPHONE NUMBER
25	Medical Examiner's Signature	Date	
26	Please return this form, your narrative report, copies of your office records, and the claimant's RRB claim number to:		

IMPORTANT NOTICES

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

PRIVACY ACT AND PAPERWORK REDUCTION NOTICE

The information requested on this form is authorized by Section 7(b)(6) of the Railroad Retirement Act. While you are not required to respond, your cooperation is needed to provide information necessary to complete processing of the named employee's claim.

We estimate this form takes an average of 25 minutes per response to complete, including the time for reviewing the instructions, getting the needed data, and reviewing the completed form. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing completion time, to Chief of Information Resources Management, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611-2092.

Make all capital letters

Computer Matching and Privacy Protection Act Notice

In addition to the uses of information described in the Privacy Act Notice on the form(s) or application(s) you have completed, The Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) requires the Railroad Retirement Board to advise you that information you have provided may be used, without your consent, in automated matching programs. These matching programs are a computer comparison of RRB records with records kept by other Federal, state, or local governmental agencies. Information from these programs can be used to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

ATTACHMENT

#1

5	DAYTIME TELEPHONE NUMBER →	Area Code	Telephone Number

#2 Reformat Section 15 as follows:

SECTION 15 - Certification

With the understanding that section 13 of the Railroad Retirement Act (45 U.S.C. 231l) provides that anyone who makes false or fraudulent statements or claims for the purpose of causing an award or payment under the Railroad Retirement Act is subject to a fine of up to $10,000, or imprisonment of up to one year, or both, I certify that the information I have furnished is correct to the best of my knowledge.

22	Medical Examiner's Signature and Date	Date
23	Medical Examiner's Printed Name, Title, and National Provider Number	National Provider Number
24	Medical Examiner's Address and Telephone Number	Area Code / Telephone Number

Please return this form, your narrative report, copies of your office records and the claimant's RRB claim number to:

RAILROAD RETIREMENT BOARD