

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 no 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	_____ →	

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. _____ → | <input type="checkbox"/> Grand Mal
<input type="checkbox"/> Petit Mal
<input type="checkbox"/> Jacksonian
<input type="checkbox"/> Psychomotor |
| | b | Check the appropriate description. _____ → | <input type="checkbox"/> Nocturnal
<input type="checkbox"/> 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? _____ → | <input type="checkbox"/> YES ► Go to Item d
<input type="checkbox"/> 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? _____ → | <input type="checkbox"/> YES ► Go to Item b
<input type="checkbox"/> NO ► Go to Item 12 |
| | b | Describe the precipitating factors. | |

Section 8 Duration of Seizures

12 Describe the duration of the seizures.

Section 9 Treatment13 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 Functions14 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? 	<input type="checkbox"/> YES ► Go to Item b <input type="checkbox"/> 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		
		<input type="checkbox"/> <input type="checkbox"/>		
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

With the understanding that section 13 of the Railroad Retirement Act (45 U.S.C. 2311) 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 or 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	Date
23	Medical Examiner's Printed Name and Title	National Provider Identifier
24	Medical Examiner's Address and Daytime 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:

Important Notices

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

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 aspects of this form, including suggestions for reducing completion time, to Chief of Information Management, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611-2092.

COMPUTER MATCHING AND PRIVACY PROTECTION ACT NOTICE

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.