United States of America
Railroad Retirement Board

Form Approved
OMB No. 3220-0039

SUPPLEMENTAL DOCTOR'S STATEMENT

Social Security Number

Patient's Name

INSTRUCTIONS TO DOCTOR: ***Please complete all items and return this form*** in the enclosed envelope to the Railroad Retirement Board (RRB) ***immediately***. No additional sickness benefits can be paid to this patient until this supplemental medical form is completed and returned. This information is to be supplied without expense to the RRB. Also read the "Important Notice" on the previous page of this form.

1. Have you examined or treated the patient for illness or injury? ☐ Yes ☐ No
   If "Yes," give the date you last examined or treated the patient: _____

2. Please give:
   A. Diagnosis: _____
   B. Current objective finding: _____
   C. Complications (show any factors retarding recovery): _____
   D. Current response to treatment: _____

3. Did the patient require surgery? ☐ Yes ☐ No – Go to Item 4
   If "Yes" - A. Indicate the type of surgery: _____
   B. Date of most recent surgery: _____

4. If maternity, give estimated or actual date of delivery: _____

5. Do you believe the patient is now able to work without restriction in his/her last occupation?
   A. ☐ Yes – Give the date the patient became able to work: _____
   B. ☐ No – Give an estimated return-to-work date and explain how the medical evidence shows the patient is still disabled.
   Estimated return-to-work date (*if indefinite, give estimated date*): _____
   Explanation: _____

6. Has the patient reached maximum medical recovery? ☐ Yes ☐ No – Go to Item 7
   If "Yes" - A. Give the date the patient reached maximum recovery: _____
   B. Is the patient able to do some kind of work? ☐ Yes ☐ No

7. I certify that the information I am giving is true, complete, and correct. I understand that criminal and civil penalties may be imposed on me for false or fraudulent statements or for withholding information to cause or prevent payment of benefits by the RRB.

Signature of Doctor	Degree/Title
Name of Doctor *(Print or Type)*	Date
Address *(Print or Type)*	Office Telephone Number *(Include area code)* ( )
City, State, ZIP Code	National Provider Identifier