



- **I wish to have sight of the report provided in Part B before it is submitted to Teachers' Pensions**  
(If yes, you are advised to make arrangements to view this report before it is sent to Teachers' Pensions)

Yes  No

- **I give my permission for the report in Part B to be supplied to Teachers' Pensions**

Yes  No

Signed

Date

**If you are an active member, please forward this form, together with your application form to your employer who will then forward it to Teachers' Pensions.**

**If you are a member with preserved benefits please return the fully completed form, with the Application for Ill-health Retirement Benefits, to:-**

**Teachers' Pensions  
Mowden Hall  
Darlington  
County Durham  
DL3 9EE**

## Part B - To be completed by the Occupational Health Doctor.

Where this is not possible, your GP, Specialist or Consultant can complete the medical report. The doctor should refer to the accompanying Guidance Notes before completing the medical evidence section. Ill-Health Retirement Benefits are awarded on the basis of the information provided, therefore it is essential that the questions below are addressed. **The doctor should refer to the guidance notes which contain information relevant to each of the questions.**

- 1 Please list all of the relevant **currently diagnosed medical conditions**, giving the date of onset for each.

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- 2 Please provide details of the reported symptoms, objective clinical findings and results of investigations, for each of the above medical condition(s).

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- 3 Please describe how the condition(s) affects **the applicant's general health and capability**.

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- 4 Please provide **details of all relevant treatment** the applicant has received for each of the conditions you have listed above.

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5 Please provide **details of any other interventions** that have been tried, e.g. physical therapy, surgical intervention, psychotherapy or formal counselling

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6 With normal therapeutic intervention, please comment on **the likelihood of improvement in functional abilities before normal retirement age**. (Age 60 if a member of scheme prior to 1 April 2007 or age 65 for post 1 April 2007 members).

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7 Please explain how the relevant medical condition(s) impacts on the applicant's **ability to carry out the normal role**. The question refers to any role relevant to the applicant's skills, qualifications and experience, in any relevant setting, full or part time. **See guidance notes.**

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8 Please describe what efforts at **rehabilitation, workplace adjustment, work content or pattern adjustment, increased support or redeployment** have been considered and / or made in this case?

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9 Does the current incapacity arise out of any unresolved workplace issues? if so, please explain

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10 Please summarise **the evidence** you consider to be relevant to **the applicant's future ability to carry out their normal or adjusted duties**. The question refers to any role relevant to the applicant's skills, qualifications and experience, in any relevant setting, full or part time. **See guidance notes.**

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11 Please summarise **the evidence** you consider to be relevant to **the applicant's future ability to carry out any regular employment**. **It is essential that this question is answered in all cases. Please see guidance regarding the two tier scheme.**

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**Please attach copies of any specialists' reports which you have in relation to this applicant that might assist in processing the application.**

## PART C - Terminal Illness and Harmful Information

Does the applicant have a medical condition that has a serious impact on life expectancy?

Yes  No

If yes, and information is available, please include a copy of the relevant specialists report.

Is the applicant aware of the diagnosis? Yes  No

Is the applicant aware of the prognosis? Yes  No

Your report will be treated as confidential. However, it is subject to the data protection act (subject access modification) (health) order 2000. if you consider that any information in your report is likely to be harmful to the applicants' health, for example, life expectancy, please include this on a separate sheet clearly marked **Harmful Information**.

I am this person's

Occupational physician /  
accredited specialist occupational physician

General Practitioner

Hospital Doctor / Accredited Hospital Specialist

(Specialism \_\_\_\_\_)

Signed \_\_\_\_\_

Date \_\_\_\_\_

Print Name \_\_\_\_\_

GMC Number \_\_\_\_\_

Contact Tel Number \_\_\_\_\_

Email Address \_\_\_\_\_

Address \_\_\_\_\_

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