



San Francisco Employees' Retirement System
 1145 Market Street 5th Floor, San Francisco, CA 94103
 Telephone (415) 487-7000, 8 a.m. – 5 p.m. Monday-Friday

Physician(s) Information
 DISABILITY RETIREMENT APPLICATIONS ONLY

1. Member Information and Current Address

Name (First, Middle Initial, Last)	Social Security Number	Daytime Phone Number
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Current Mailing Address (Street Address, Apartment Number)

Current Mailing Address (City, State, Zip Code)

2. Physician Information

Please provide the names, addresses and phone numbers of all the physicians who have treated or evaluated you for the conditions regarding your disability, include your Primary Physician. Please identify your Primary Physician and which physicians are "WC". Please print clearly.

MEDICAL PROVIDER'S NAME	MEDICAL PROVIDER'S ADDRESS
<input type="checkbox"/> Check for WC	Street Address:
	City, State, Zip
	Telephone
<input type="checkbox"/> Check for WC	Street Address:
	City, State, Zip
	Telephone
<input type="checkbox"/> Check for WC	Street Address:
	City, State, Zip
	Telephone
<input type="checkbox"/> Check for WC	Street Address:
	City, State, Zip
	Telephone
<input type="checkbox"/> Check for WC	Street Address:
	City, State, Zip
	Telephone
<input type="checkbox"/> Check for WC	Street Address:
	City, State, Zip
	Telephone

If you have more doctors than spaces provided, please continue on another sheet.

Make sure that you have completed all sections above and mail or deliver the completed form to:

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