NMI SETTLEMENT FUND

POST OFFICE BOX 501247, SAIPAN, MP 96950

REPORT OF PHYSICIAN ON CONTINUING DISABILITY

(For use on subsequent annual examination. Use Form SF-3A for first examination)

NOTE: The report must reflect the disabling condition since the last examination; i.e., the first of subsequent annual examination. This report may be used in determining continuing eligibility for disability benefits.

1. Member's Name :	2. SOCIAL SECURITY NUMBER: / /	3. DATE OF BIRTH:	4. HOSPITAL NUMBER:

5. GENDER: ☐ MALE ☐ FEMALE	6. WEIGHT: ______ lbs.	7. HEIGHT: ____' ____"	8. BLOOD PRESSURE AT TIME OF EXAMINATION: ________/________

9. DESCRIPTION OF DISABILITY/ILLNESS (DESCRIPTION MAY BE SIMILAR AS THAT LISTED IN FORM SF-3A).

(Please use back page for additional remarks)

10. DO YOU OBSERVE ANY IMPROVEMENT OVER THE LAST EXAMINATION? ☐ YES ☐ NO	11. IF "YES" TO ITEM (10), HOW MUCH IMPROVEMENT? ________________%

12.DESCRIBE IMPROVEMENT:

13. AS A RESULT OF THE HEALTH IMPROVEMENT AS DESCRIBE IN ITEM (12), DO YOU FEEL DISABLED PERSON NOW ENGAGE IN FOLLOWING EMPLOYMENT? ☐ REGULAR ☐ LIMITED/PART TIME ☐ OTHER (SPECIFY): ____________	14. IF "NO" TO ITEM (10) WHEN MAY DISABLED PERSON ENGAGE IN GAINFUL EMPLOYMENT? ____________

By affixing signature below, the named attending physician hereby declares, under perjury, that the information provided in this report is true and correct to the best of his/her knowledge. Knowingly providing any false or misleading information, in an attempt to defraud the CNMI government, would be considered a misdemeanor and punishable under the laws of the Commonwealth of the Northern Mariana Islands.

15. NAME AND SIGNATURE OF ATTENDING PHYSICIAN ____________	16. DATE OF EXAMINATION:	17. DATE OF REPORT:

18. NAME AND ADDRESS OF CLINIC (P.O. BOX OR STREET NUMBER): ____________	19. MEDICAL LICENSE NUMBER:

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9a. ADDITIONAL COMMENTS/REMARKS, IF ANY.