NMI SETTLEMENT FUND

POST OFFICE BOX 501247, SAIPAN, MP 96950

ATTENDING PHYSICIAN'S REPORT

(For use on First Examination only. Use Form SF-3B for subsequent annual examination)

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

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

9. IS DISABILITY/ILLNESS TOTAL AND PERMANENT:	10. IF "NO" TO ITEM (10) GIVE ESTIMATE WHEN DISABILITY/ILLNESS MAY TERMINATE
☐ YES ☐ NO	_____

11. DESCRIBE THE IMPAIRMENT, INJURY OR ILLNESS OF DISABLED MEMBER. PLEASE INDICATE ADDITIONAL COMMENTS/REMARKS ON SECTION 24, IF ANY.

12. ESTIMATE DATE WHEN DISABILITY BEGAN (IF EXACT DATE IS NOT KNOWN) _____	13. WAS DISABLED MEMBER PHYSICALLY OR MENTALLY ABLE TO ENGAGE IN GAINFUL EMPLOYMENT ON THE DATE OF INJURY/ILLNESS? ☐ YES ☐ NO
14. IS SHE/HE PHYSICALLY OR MENTALLY ABLE TO ENGAGE IN GAINFUL EMPLOYMENT NOW? ☐ YES ☐ NO	15. IF "NO" TO ITEM (14), HOW LONG DO YOU ANTICIPATE BEFORE THE DISABLED MEMBER CAN RETURN TO GAINFUL EMPLOYMENT? WITHIN _____ (DAYS/MONTHS/YEARS)
16. IF "YES" TO ITEM (14), WOULD IT BE SIMILAR TO ANY JOB SHE/HE PERFORMED IN THE PAST YEAR? ☐ YES ☐ NO	17. IF "NO" TO ITEM (16), WHAT TYPE OF EMPLOYMENT OR WORK WOULD SHE/HE BE ABLE TO PERFORM? _____

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18. DO YOU EXPECT DISABILITY TO LAST LONGER THAN 12 MONTHS FROM DATE OF THIS REPORT? ☐ YES ☐ NO	19. IF "YES" TO ITEM (18), HOW LONG?
20. COULD RECOVERY BE HASTENED IF PATIENT SOUGHT REHABILITATIVE ASSISTANCE? ☐ YES ☐ NO	21. IN THE EVEN OF TOTAL DISABILITY, WHEN SHOULD DISABLED MEMBER RETURN FOR NEXT MEDICAL EXAMINATION?

24. ADDITIONAL COMMENTS/REMARKS, IF ANY. ATTACH ADDITIONAL PAGE(S), IF NECESSARY.

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.

NAME AND SIGNATURE OF ATTENDING PHYSICIAN	DATE:
NAME AND ADDRESS OF CLINIC (P.O. BOX OR STREET NUMBER):	MEDICAL LICENSE NUMBER: