



# 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:
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5. GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	6. WEIGHT: _____ lbs.	7. HEIGHT: _____ ' _____ "	8. BLOOD PRESSURE AT TIME OF EXAMINATION: _____ / _____
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9. DESCRIPTION OF DISABILITY/ILLNESS (DESCRIPTION MAY BE SIMILAR AS THAT LISTED IN FORM SF-3A).

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(Please use back page for additional remarks)

10. DO YOU OBSERVE ANY IMPROVEMENT OVER THE LAST EXAMINATION? <input type="checkbox"/> YES <input type="checkbox"/> NO	11. IF "YES" TO ITEM (10), HOW MUCH IMPROVEMENT? _____ %
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12. DESCRIBE IMPROVEMENT:

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13. AS A RESULT OF THE HEALTH IMPROVEMENT AS DESCRIBE IN ITEM (12), DO YOU FEEL DISABLED PERSON NOW ENGAGE IN FOLLOWING EMPLOYMENT? <input type="checkbox"/> REGULAR <input type="checkbox"/> LIMITED/PART TIME <input type="checkbox"/> OTHER (SPECIFY): _____	14. IF "NO" TO ITEM (10) WHEN MAY DISABLED PERSON ENGAGE IN GAINFUL EMPLOYMENT? _____ _____
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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:
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18. NAME AND ADDRESS OF CLINIC (P.O. BOX OR STREET NUMBER): _____	19. MEDICAL LICENSE NUMBER:
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