ERSRI Employees' Retirement System of Rhode Island

ANNUAL MEDICAL UPDATE FORM

Please print clearly in black ink.

Section 1: Annual Medical Update

For Members Receiving a Disability Retirement Allowance

Please take this page with you to one of your doctor's appointments during 2025.

Name of Member _____ *Member Date of Birth (mm/dd/yyyy)* _____

Doctor's Name _____ *Date of Examination (mm/dd/yyyy)* _____

Section 2: To Be Completed By Your Doctor (Due by December 31, 2025)

Please provide a response to the following statement based on your medical opinion.

The Member likely remains unable to work in the position from which he or she retired.

❑ Yes ❑ Further independent examination is recommended to determine.

Please attach a copy of the Member's **current medical report** (required).

Additional Notes (optional):

Section 3: Doctor's Signature

Doctor's Signature _____ *Date of Signature (mm/dd/yyyy)* _____

This box is only applicable for Members who are unable to see a doctor during 2025. Member, please check the reason below and return to ERSRI.

❑ I cannot afford to see a doctor. ❑ I do not have a doctor. ❑ My doctor will not sign the form.

❑ Other (please explain): _____

Return the completed form to the address below. Incomplete or inaccurate forms will not be processed.

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