DISABILITY RETIREMENT APPLICATION
MEDICAL REPORT

CO-649 Rev. 8-2015

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
RETIREMENT SERVICES DIVISION

Complete this form, attach to CO-898, Application
For Retirement, and forward both to Retirement Services Division

PATIENT'S NAME (Last)	First Name	M.I.	AGENCY WHERE EMPLOYED

PATIENT'S ADDRESS *(City, State, Zip Code)*	EMPLOYEE ID

MAJOR HEALTH COMPLAINTS - AS STATED BY THE PATIENT

RELEVANT PAST HISTORY - HOSPITALIZATIONS, LABORATORY FINDINGS, X-RAY REPORTS, ETC.

PRECIPITATING EVENTS - INCLUDING ACCIDENTS

CURRENT HISTORY - TYPE, SYMPTOMS AND SIGNS, ONSET *(Specify categories)* AND DURATION

- ☐ EXTREMITIES AND BACK
- ☐ PERIPHERAL SPINAL NERVES
- ☐ CENTRAL NERVOUS SYSTEM
- ☐ RESPIRATORY SYSTEM
- ☐ CARDIOVASCULAR SYSTEM
- ☐ HEMATOPOIETIC SYSTEM
- ☐ VISUAL SYSTEM
- ☐ EAR, NOSE, THROAT
- ☐ DIGESTIVE SYSTEM
- ☐ REPRODUCTIVE/URINARY SYSTEM
- ☐ ENDOCRINE SYSTEM
- ☐ SKIN
- ☐ MENTAL ILLNESS

ABNORMAL PHYSICAL FINDINGS

DIAGNOSIS AND DEGREE OF IMPAIRMENT OF FUNCTION

COURSE OF TREATMENT, CURRENT TREATMENT PLAN, PATIENT RESPONSE

CURRENT MEDICATIONS

PROGNOSIS - INCLUDING REHABILITATION POTENTIAL

NAME OF PHYSICIAN *(Signature)*	CONN. MEDICAL LICENSE NO.	DATE

NAME OF PHYSICIAN *(Type or Print)*