Georgia Municipal Employees Benefit System (GMEBS)
The Burgess Building
201 Pryor Street, SW, Atlanta, GA 30303-3606 * Phone (404) 688-0472 * Fax (678-686-6289 * Toll Free 1-888-488-4462 * gmanet.com

PHYSICIAN'S DISABILITY CERTIFICATION
(To be completed by Disability Applicant's Examining Physician)

[Note to Disability Applicant: completion of this form alone may not be sufficient to make you eligible for disability benefits under the retirement plan. Additional eligibility or certification requirements may apply.]

I have examined: _____, and I hereby
(Please print or type Disability Applicant's name)
certify that: **(1)** he or she is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or to be of long continued and indefinite duration; **(2)** such disability commenced on: _____; and **(3)** such
(Please type or print date)
disability was not self-inflicted, incurred in military service, incurred in the commission of a felonious enterprise, or the result of the use of narcotics or drugs or habitual alcoholism.

PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION:

_____
Examining Physician's Full Name License No.

_____
Mailing Address

_____
City State Zip Code

_____
Phone Number

PLEASE SIGN AND DATE BELOW:

_____ _____
Physician's Signature Date