MARSHALL ISLANDS SOCIAL SECURITY ADMINISTRATION
P.O. Box 175, Majuro, Marshall Islands, MH 96960
Phone: (692) 625-3101 *** Fax: (692) 625-4570 *** E-mail: missa3@ntamar.com

MEDICAL REPORT

PRIVACY ACT/PAPERWORK REDUCTION ACT NOTICE: The Marshall Islands Social Security Administration (MISSA) is authorized to collect the information on this form under section 45(8) of the Social Security Act. The information on this is needed by MISSA to complete processing of the named patient's claim for disability benefits. While giving us the information on this form is voluntary, failure to provide the requested information may prevent an accurate or timely decision on the named patient's claim. Although the information you furnish on this form is almost never used for any purpose other than making a determination about disability, such information may be disclosed by MISSA to another person or governmental agency only with respect to Social Security programs requiring the exchange of information between MISSA and another agency.

TIME NEEDED TO COMPLETE THIS FORM: We estimate that it will take you about 30 minutes to complete this form. This includes the time needed to read the instructions, gather the necessary facts and fill out the form. If you have comments or suggestions about this form, please write to the Marshall Islands Social Security Administration, P.O. Box 175, Majuro MH 96960, attention of Claims and Benefits Department.

Patient's name (Last, First, Middle):	Sex: [ ] Male [ ] Female	Height: In cm: In inches:
Patient's address:	Age:	Weight: In lbs. In kgs.
Highest Educational Attainment:	Nature of current/latest work:	Employer name:
Other skills/profession:	Position title at current/latest work:	Employer address:

Notice to Physician: Please include sufficient details of history, physical and diagnostic finding, clinical course, therapy and response, to enable the reviewing medical examiner make and independent determination as to the severity and duration of the impairment.

1. HISTORY:

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Claimant's alleged onset date of disability:	Date you first examined patient:	Date of most recent examination:

HISTORY (*continued from page 1*):

2. PHYSICAL & DIAGNOSTIC FINDINGS (Please give detailed description)

3. LABORATORY AND SPECIAL STUDIES (Give results of all pertinent laboratory tests and other studies with dates. In case of ECG, X-Ray, Biopsy, etc., please give detailed description, with dates.

4. DIAGNOSIS: (Please indicate also if disability is expected to result in death or to last at least 12 months)

5. TREATMENT AND RESPONSE:

6. DOCTOR'S OPINION about what the patient can still do despite his or her impairment (e.g. the individual's ability to perform work-related activities, such as sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling.)

Continue next page...

Doctor's opinion....
7. MEDICAL RECOMMENDATION:

Note: MISSA reserves the right not to allow the patient to see this medical report and results of diagnostic and/or laboratory tests, if, upon the judgment and recommendation of the attending physician and/or the medical examiner, release of this report directly to the patient may have an adverse effect on that individual.

Please provide the original copy of this medical report to Dr. _____, MISSA's designated Medical Examiner.

Physician's name (Last/First /Middle) (Type or Print)	Signature:
Position /Title:	Date:
Name & Address of Hospital	Telephone no: E-mail address: