United States of America
Railroad Retirement Board

Form Approved
OMB No. 3220-0039

Statement of Sickness

Instructions: ***This form is to be executed by (1) a healthcare provider trained in medical, surgical, dental or psychological diagnosis of the infirmity described, (2) a certified nurse/midwife in cases of pregnancy or childbirth, (3) a supervisory official of a hospital or similar institution, (4) a chiropractor, (5) a Physician Assistant - Certified, or (6) a nurse practitioner. This form should be completed and returned to the patient immediately for prompt mailing; otherwise he/she may lose benefits. Supplementary medical information may be attached or furnished directly to the Railroad Retirement Board (RRB) at the address shown below. If such information is furnished, please include the patient's social security number and name on the report. Please complete section 2 on the reverse side if patient is incapable of signing forms.***

The RRB is not liable for any charge in connection with completing this form.

1. Patient's Name (First, Middle, and Last)

2. Patient's Social Security Number

3. Have you examined or treated the patient for his or her injury or illness? o Yes o No – **Go to Item 9**

a. Date patient became sick or injured

b. List all dates of examination and treatment for this infirmity

c. Probable date of next examination

4. Diagnosis and concurrent conditions

5. Does the patient's condition require surgery? o Yes o No – **Go to Item 6**

a. Date on which surgery was or will be performed

b. Surgical procedure that was or will be performed

6. Does the patient's condition require hospitalization?

o Yes – Enter the period of hospital confinement: From _____ To _____

o No

7. If patient is not working because of maternity or childbirth, complete 7a and 7b.

a. Date patient became unable to work s

b. Estimated or actual date of delivery s

8. Give the date you believe the patient became or will become able to resume work in his or her occupation. (If indefinite or unknown, please give an estimated date.) s

9. I certify that the information I am giving is true, complete, and correct. I understand that criminal and civil penalties may be imposed on me for false or fraudulent statements or for withholding information to cause or prevent payment of benefits by the RRB.

Please print or type:

Name of HEALTHCARE PROVIDER	Signature of HEALTHCARE PROVIDER	Degree/Title
Address	Office Telephone Number (Include Area Code) ( )	Date
	National Provider Identifier	

PAPERWORK REDUCTION ACT NOTICE TO HEALTHCARE PROVIDER

Medical evidence is needed to support the payment of claims for sickness benefits under the Railroad Unemployment Insurance Act (RUIA). The RRB is authorized to collect this information under section 12(i) of the RUIA. You are not required to furnish this information. If you do not, however, no benefits can be paid to your patient. We estimate this form and the form on the back of this page take an average of 8 and 6 minutes to complete, respectively. The estimates include the time for reviewing the instructions, getting the needed data, and reviewing the completed forms. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing completion time, to the Associate Chief Information Officer for Policy and Complaince, Railroad Retirement Board, 844 N Rush Street, Chicago, Illinois, 60611-1275. Send completed forms to:

U.S. RAILROAD RETIREMENT BOARD - RUIA
POST OFFICE BOX 541186
Houston, TX 77254-1186