

GUIDE 03 / PREPARE YOUR EVIDENCE

Medical records inventory and organization

Build a readable, traceable collection without losing originals or mistaking a large file for a complete record.

What you will leave with: Create a source inventory, a working copy, and a specific missing-records list.

Use this guide with current official instructions. Complete worksheets privately; do not send sensitive information through the website.

Start with a safe working system

This is a practical organization method, not an OPM-required filing format. Work on your own device in a private folder. Keep original downloads unchanged in an Originals folder and make a separate Working folder for sorting. Do not overwrite a signed statement, edit a provider's findings, or remove pages from the only copy. The goal is to help you and a reviewer find the evidence and understand where it came from.

Do not enter diagnoses, provider details, medical documents, or personal identifiers into this website. The staging site does not accept medical uploads. Complete the worksheet privately and use only an independently verified secure delivery method when one becomes available.

Inventory what you actually have

1. List each file before combining anything. Record its source, download date, page count, and the treatment dates it covers.
2. Open every file. Check the first, middle, and final pages, page orientation, and whether text is readable at ordinary magnification.
3. Distinguish appointment notes, test reports, hospital records, provider statements, and administrative items. A portal summary is not necessarily the underlying visit note.
4. Use a neutral file label such as 2026-08-12_ClinicA_VisitNote.pdf. Avoid putting a Social Security number or other sensitive identifier in filenames.

Your private worksheet

File label / source organization / record type:

Treatment dates covered / received date / supplied page count:

Readable? Complete? Password protected? Missing attachments?

Identify gaps with a purpose

Compare your collection with the conditions and work difficulties you intend to describe. Look for the visit where a problem was evaluated, relevant testing, treatment changes, response to treatment, and documented restrictions. Do not assume everyone needs the same number of years of records. Older records can explain history; a recent clinical update can address your current situation. OPM's SF 3112 instructions emphasize current diagnosis, prognosis, and treatment information.

1. List each provider or facility you actually saw for the relevant issue. Compare known visits against the dates in your files.
2. Request missing records through that organization's records process. Specify the visit range and record types rather than simply asking for everything.
3. Record the request date, promised response, any fee, and the next follow-up date.
4. Ask the treating clinician to clarify missing medical information. Do not fill in a clinical conclusion yourself.

Make a reviewer-friendly working set

Sort working copies consistently, for example by provider and then encounter date. If you combine files, create a simple index listing each document and its location. Page references should identify both the combined page and original source when practical. Bookmarks are helpful conveniences, not official requirements. Keep an unmodified copy of every source so a reference can always be checked.

Fictional worked example

Alex downloads three files: Clinic A, 42 pages; Hospital B, 18 pages; and a 6-page portal summary. The inventory shows that a June specialist visit is missing. Alex requests that visit and logs it as pending rather than claiming the set is complete. A working index points to Hospital B's discharge note at combined pages 43-48, while its original file remains unchanged.

Avoid common organization traps

- Do not treat an appointment list as proof of what the clinician documented.
- Do not highlight or annotate your only original. Put questions in a separate notes file.
- Do not silently remove duplicate, blank, or unrelated-looking pages from a service submission. Confirm what you intend to supply before delivery; all supplied pages count for TFDR pricing.
- Do not change a scan to make a restriction sound stronger or omit contrary information from a summary.
- Do not assume document organization establishes eligibility. OPM evaluates the application; organization makes the underlying material easier to navigate.

Completion check and next step

- [] Originals are preserved and the working collection is readable.
- [] Every file has a source, date range, and page count.
- [] Missing visits and unanswered requests have owners and follow-up dates.

- [] Index references resolve to the right document.
- [] Questions for providers are separate from medical findings.
- [] No sensitive information has been entered on this staging website.

Your private worksheet

Most important missing item and why it matters:

Who will request it, and by what date?

What is ready for a provider conversation now?

What remains uncertain and must be verified?

Official sources

OPM: SF 3112, Documentation in Support of Disability Retirement Application · OPM: FERS types of retirement - disability retirement and current application instructions

Reviewed October 14, 2026. Check current official sources before acting.

TFDR provides independent non-attorney education. These resources are not official forms, legal advice, medical opinions, or individualized tax advice. You prepare and submit your own application. OPM determines eligibility.