GUIDE 11 / PREPARE YOUR EVIDENCE

Factual medical summary for physician review

Prepare an accurate patient summary that helps your physician find the relevant history.

What you will leave with: Create a clearly labeled, source-linked patient summary without generating medical opinions.

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

Label the document and its purpose

A patient-prepared summary can make a complicated history easier to review, especially when several practices hold records. It is a navigation aid, not a physician statement, diagnostic assessment, or proof that a retirement requirement is met. Put "Patient-prepared factual summary for clinician review" at the top, add the preparation date, and identify the period covered. Leave space for questions and corrections rather than a prewritten approval or signature line.

Use neutral wording. "I report," "the note records," and "the test report states" identify the origin of information. Avoid "this proves," "permanently disabled," or "medically unable" unless you are accurately attributing a clinician's documented conclusion. A clinician must independently assess any medical opinion and author the conclusions they support.

Create a source inventory first

1. List each practice, specialty, treatment period, and records currently available. Identify missing visits or reports.

2. Name files consistently with dates, provider, and document type. Keep an untouched original and a separate working copy.

3. Give each source a simple reference, such as R01, and record its page range. Use visit dates rather than download dates for chronology.

4. Start the timeline with relevant onset or changes, then treatment and work events. Include earlier history when it helps explain the present situation; there is no blanket rule excluding records older than a year.

If two records disagree, preserve both and flag the discrepancy. Do not choose whichever entry sounds more favorable. An emergency note, longitudinal specialist note, and patient recollection may describe different contexts. Ask the treating practice to clarify an actual error or explain the difference.

Write short entries with attribution

Field	What to record
Event date	Exact date, or clearly labeled estimate
Source	Provider, record type, reference and page

Field	What to record
Documented fact	Finding, diagnosis, treatment change, or stated restriction
Your experience	Symptoms or response you personally report
Follow-up	Missing report, question, or next appointment

Use a few sentences per meaningful event. Include treatment that helped, symptoms that improved, and plans still underway. Describe medication effects only as documented or personally experienced; do not assume a listed side effect occurred. A medication list alone does not show how a person functioned at work. Distinguish a condition you have been diagnosed with from one being evaluated or ruled out.

Connect the history to questions about work

Attach the actual position description and a short duty worksheet. Describe the work task, your observed difficulty, and the medical source if one already addresses it. Ask whether the clinician can explain the relationship and any appropriate restrictions. Do not turn personal observations into prescribed limits or create a clinical explanation that the record does not contain.

Your private worksheet

Current duty and source:

Observed difficulty, frequency, and period:

Relevant record references:

Adjustment or treatment tried and actual result:

Question for the clinician, including any uncertainty:

For FERS, the expected duration concerns at least one year from the filing date. Give the clinician your planned filing date and ask for an independent prognosis relative to it. Do not substitute "one year from this summary" or claim that a chronic diagnosis automatically meets the standard.

Review for completeness and keep the roles clear

Check whether the summary allows a clinician to find current evaluation findings, treatment response, and missing evidence. SF 3112 requests current diagnosis, prognosis, and treatment-plan information within 60 days before filing; plan an update if appropriate while preserving relevant historical evidence. Keep administrative application questions separate from the clinical appointment.

SF 3112C assigns its medical documentation to the physician. OPM's handbook recognizes supporting documentation from other licensed practitioners within their scope, while defining physician separately. Do not assume your factual summary or every practitioner's note satisfies a requested physician statement. Ask HR or OPM to clarify author requirements when needed. Current employees initiate ORA through HR; former employees use the former-employee ORA route described by OPM.

Worked example and final check

Fictional worked example

Taylor lists a specialist visit as R03, page 8, noting the recorded treatment change. Taylor separately writes, "I report fewer episodes after this change, but two scheduled meetings were still interrupted in the following month." The physician is asked to assess the significance of that pattern and the relevant duties. Taylor does not replace the specialist's findings with an applicant-written conclusion that the treatment failed.

[ ] Patient-prepared label and date appear on every version.

[ ] Diagnoses, observations, and clinician opinions are distinguished.

[ ] Each medical assertion has a source or an explicit self-report label.

[ ] Helpful treatments and contradictory information are included.

[ ] Questions remain questions until the clinician answers.

[ ] Original records are preserved and identifying information is shared only through approved channels.

[ ] No medical material is entered into public website worksheets or general inquiry forms.

Official sources

OPM: SF 3112 disability documentation package · OPM: CSRS/FERS Handbook, Chapter 60 · 5 CFR 844.103: FERS disability eligibility · OPM: FERS disability eligibility and current application route · HHS: Accessing and correcting your medical records

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

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