

GUIDE 04 / PREPARE YOUR EVIDENCE

Medical chronology workbook

Turn scattered records into a factual timeline that keeps clinical findings, personal observations, and workplace events distinct.

What you will leave with: Create a source-linked timeline and a short list of clarification questions.

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

Know what the chronology can do

A chronology is a navigation aid. It can reveal missing records, help you prepare for a provider appointment, and make it easier to locate changes over time. It is not a medical opinion, legal argument, substitute for the source records, or guarantee of approval. Use it to describe what the documents say. Keep your own recollections visibly separate so a reader can distinguish an observed experience from a clinician's finding.

Complete this workbook privately. Do not enter health information or upload records on the staging website. Preserve source documents unchanged; add corrections through a separate note and, when needed, the original record custodian's correction process.

Choose a useful starting point

1. Begin with the earliest event needed to explain the relevant condition or its effect on your position. There is no universal TFDR-required lookback period.
2. Record the encounter date, not just the date you downloaded the document. If a report was signed later, note both when that distinction matters.
3. Add treatment changes, significant testing, documented restrictions, response to treatment, and material workplace events.
4. Use one event per row. Split a long admission or complex visit into separate rows only when it improves clarity.
5. Mark an uncertain date as approximate and explain the source of that uncertainty. Never invent a day to make sorting easier.

Build rows that can be checked

Column	What to enter
Event date	Date of visit, test, communication, or workplace event.
Source and location	File label plus page or section; preserve the original.
Documented event	Brief factual description with attribution.
Treatment or restriction	What the provider actually recorded; mark not addressed when absent.

Column	What to enter
Work connection	The specific duty affected, identifying whether this is your report or a provider statement.
Open question	Missing record, unclear term, or follow-up needed.

Keep summaries short enough to scan but specific enough to verify. "Provider documented reduced lifting tolerance" is different from "cannot work." Do not convert one into the other. A test result, diagnosis, prognosis, and work restriction answer different questions; do not assume one proves all the others.

Follow a fictional example

Fictional worked example

On April 8, Jordan reports back pain during an appointment. The note describes symptoms and treatment but no work restriction. On May 6, a clinician records a lifting restriction. Jordan's June 2 email asks HR about adjusting a task requiring movement of supply boxes. The chronology identifies the April symptoms as patient-reported, the May restriction as provider-documented, and the June request as an agency communication. It does not backdate the lifting restriction to April or state that HR denied the request unless a response documents that outcome.

This distinction protects accuracy. A later statement can describe earlier history, but the chronology should say that it is a later account. If two sources disagree, record the disagreement and ask for clarification. Do not choose the version that sounds more persuasive and erase the other.

Review the timeline for missing information

1. Read it from beginning to end and identify unexplained date gaps. A gap may reflect missing records, stable treatment, or something else; label the question instead of drawing a conclusion.
2. Compare descriptions against the source pages, including details that qualify or limit a statement.
3. Check that each workplace connection names a concrete duty, attendance issue, or documented restriction rather than only a diagnosis.
4. Make a separate provider-question list for clinical gaps and an agency-question list for workplace records.
5. Update the chronology when new evidence arrives, recording the version date so an older draft is not mistaken for the current one.

Private worksheet and completion check

Your private worksheet

Event date / source document / page:

What is documented, and whose statement is it?

Treatment, response, or restriction actually recorded:

Specific duty or attendance issue, with its separate source:

Uncertainty, missing item, and person to ask:

Date clarification was received and where it is stored:

☐ Every substantive entry has a source or is clearly labeled personal recollection.

☐ Approximate dates remain visibly approximate.

☐ No medical conclusion has been invented.

☐ Conflicting records are acknowledged.

☐ The chronology supplements rather than replaces original evidence.

☐ A short, actionable clarification list is ready.

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.

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