

**COVID-19 MEDICAL CERTIFICATION A:
DATE OF ONSET
(To Be Completed by a Medical Professional)**



TEACHERS' RETIREMENT SYSTEM
OF THE CITY OF NEW YORK (TRS)
55 Water Street, New York, NY 10041
www.trsnyc.org • 1 (888) 8-NYC-TRS

- Please complete this Medical Certification in support of an application for COVID-19 Accidental Death Benefits pursuant to Chapter 89 of the Laws of 2020. This Certification is to be submitted when a COVID-19 laboratory test result is unavailable. Please submit the completed Certification to TRS as follows:
 - ♦ By email to accidentaldeathbenefit@trs.nyc.ny.us
 - ♦ By e-fax at (212) 918-9253
 - ♦ By mail to TRS at 55 Water Street, New York, NY 10041. Please note that there may be some delay in processing mailed forms during the pandemic.
- If you require assistance, please call TRS at (212) 510-4028, which is a dedicated line we have established for inquiries related to the accidental death benefit.

This certification is for the below deceased member of TRS.

Member's First Name MI Last Name Member's Social Security Number (last 4 digits only)
 - -

PART A: Please complete the following.

1. In my professional opinion, the member named above contracted COVID-19 on or before _____, 2020.
(MM/DD)
2. I first made this determination on the following date: _____. (Date may be before or after the death of the member.)
(MM/DD/YYYY)
3. Please briefly explain your basis for this opinion as to when the decedent contracted COVID-19:

PART B: Please complete the following and sign and date below.

Printed Name: _____ License Number: _____

Best Contact Information: _____

I certify that I am a _____ (physician, nurse practitioner, or physician's assistant) who is in good standing in _____ (state) or who is authorized to practice in New York State by Executive Order during the declared COVID-19 State of Emergency. I do hereby attest that the information included in this certification and reported to TRS is true, accurate, and complete to the best of my knowledge and I understand any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

Certifier's Signature: _____ Date: _____
(MM/DD/YYYY)

TRS reserves the right to request additional information including, but not limited to, relevant medical records and professional credentials.