BERS | Board of Education Retirement System
MAILING ADDRESS | 65 COURT STREET, 16TH FL.
BROOKLYN, NEW YORK 11201-4965

You may submit this form via fax to (718) 935-4124 or (718) 935-3830.

CERTIFICATION OF COVID-19 DIAGNOSIS

CERTIFICATION OF COVID-19 DIAGNOSIS AND/OR CAUSE OF DEATH

This form should be completed by a medical professional who has treated and/or examined the decedent (including a posthumous examination).

OFFICIAL DATE OF RECEIPT

The Eligible Beneficiary of BERS member/retiree _____ (name of decedent) has applied for a COVID-19 death benefit under Chapter 89 of the Laws of 2020. In order to be eligible for this benefit, the eligible beneficiary must provide proof that:

(a) the decedent was diagnosed with COVID-19 either by a positive laboratory test or as diagnosed by a licensed, certified, registered or authorized physician, nurse practitioner, or physician's assistant currently in good standing in any state or the District of Columbia, or a physician, nurse practitioner, or physician's assistant authorized to practice in New York by Executive Order during the declared COVID-19 State of Emergency and that

(b) COVID-19 caused or contributed to the Member/Retiree's death as documented on the death certificate or as certified with a reasonable degree of medical certainty by a licensed, certified, registered or authorized physician, nurse practitioner, or physician's assistant currently in good standing in any state or the District of Columbia, or a physician, nurse practitioner, or physician's assistant authorized to practice in New York by Executive Order during the declared COVID-19 State of Emergency.

Name of Medical Professional

Occupation (check one)

☐ Physician ☐ Nurse Practitioner ☐ Physician's Assistant

License# | Registration #

State licensed in

Telephone Number | Email Address

Employer

Address

CERTIFICATION OF COVID-19 DIAGNOSIS

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I hereby certify the following (check all that apply):

☐ I am a physician, nurse practitioner, or physician's assistant licensed, registered, certified, or authorized in the state of _____, or authorized to practice in New York by Executive Order during the declared COVID-19 State of Emergency, and I am currently in good standing.

☐ I examined and/or treated the above individual during the time period: _____ (dates).

☐ This individual was diagnosed with COVID-19 on _____ (date; may be posthumous).

☐ I can confirm, with a reasonable degree of medical certainty, that COVID-19 caused or contributed to the death of the above individual.

I acknowledge and certify that this representation is accurate to the best of my knowledge.

Name: _____

Signature
REQUIRED _____ Date _____

Pursuant to the Penal Code of the State of New York, offering a document containing false statements or false information constitutes a felony punishable by a maximum of 4 years imprisonment. All documents suspected of containing false statements will be referred for investigation.