APPLICATION FOR DISABILITY PENSION

(Please type or print all information, except signature)

Date_____

Name_____

Other names by which you have ever been known:

_____

Employee # _____ Rank_____

Date of Birth:_____ Date of Hire _____

Current Assignment_____

Status of Employment _____

Home
Address_____

_____

Home Telephone _____ Work Telephone _____

Personal Email address_____

♦ ♦ ♦

ALL QUESTIONS MUST BE COMPLETED BEFORE THE PENSION BOARD WILL CONSIDER YOUR APPLICATION. IF FURTHER SPACE IS REQUIRED FOR ANY QUESTION, ATTACH ADDITIONAL PAGES, INDICATING THE QUESTION NUMBER TO WHICH THE INFORMATION APPLIES.

IN ADDITION, THE SUPPORTING DOCUMENTATION FOR YOUR APPLICATION ("Application Package") MUST BE PROVIDED WITHIN THIRTY (30) CALENDAR DAYS FROM THE DATE OF FILING YOUR APPLICATION AND IN THE MANNER SET FORTH IN THE BOARD'S "GUIDELINES AND INFORMATION SHEET FOR APPLICATION FOR DISABILITY PENSION."

1. TYPE OF DISABILITY PENSION APPLIED FOR:

_____LINE-OF-DUTY _____NON-LINE-OF-DUTY

2. MEDICAL CONDITION FOR WHICH DISABILITY PENSION SOUGHT (be specific):

_____

_____

_____

_____

3. PROVIDE SPECIFIC INFORMATION AS INDICATED:

A. Date and time of accident/injury or onset of condition:

_____

_____

_____

_____

B. Where accident/injury occurred or how condition first detected (be specific):

_____

_____

_____

_____

C. How did accident/injury occur or how was condition first detected (be specific):

_____

_____

_____

_____

D. Provide names and addresses of all witnesses:

_____

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E. Was accident/injury/condition reported to supervisor? If so, provide name and date reported.

_____

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_____

F. List the name, business address and telephone number of each medical provider (including but not limited to, physicians, surgeons, hospitals, chiropractors, physical therapists, osteopaths) who has treated or examined you, and each medical facility where you have received any treatment or examination <u>for the illness or injury for which you are applying for a disability retirement, or any condition that may be related to it and the dates of treatment</u>.

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_____

G. What medications are currently being taken (be specific):

_____

_____

_____

_____

H. Was surgery recommended? If so, by whom and when?

_____

_____

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_____

I. Was surgery performed? If so, by whom, when and with what results?

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_____

J. Has any further treatment(s) been discussed with you? If so, what is that further treatment(s) and identify by name and address with whom you discussed further treatment(s).

_____

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_____

K. State the date on which you reached maximum medical improvement (MMI), and identify by name and address all doctors who have advised you that you have reached maximum medical improvement (MMI).

L. Identify by name and address, all doctors who have advised you that you have not reached maximum medical impairment (MMI).

M. What limitations, if any, have been placed on physical activity (by whom and what restrictions)?

N. Have you ever had a similar accident/injury or medical condition in the past to the same part of the body for which this application is filed? If so, state date, place, and circumstances of that previous injury.

O. Did you ever have this same or a related medical condition prior to your employment with the Department? If so, state date(s) and circumstances.

_____

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P. If this application is based on a psychiatric or psychological condition, have you ever been diagnosed as having this same condition or any other psychiatric/psychological condition prior to or during your employment with the Department? If so, state what condition, diagnosed/treated by whom, when and where?

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Q. Summarize why you believe you are disabled and how your illness or injury prevents you from performing your usual job duties.

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4. Were you suffering any injury, disease or disability at the time of the accident(s), incident(s), or condition(s) for which you are now applying for disability retirement? If so, what was the nature of the injury, disease or disability?

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5. Have you ever applied for or received Workers' Compensation, Veterans Administration (VA) benefits, or any other form of compensation or benefits (including, but not limited to, insurance proceeds or settlement, damages as a result of a lawsuit, etc.) due to/as a result of/on account of any accident, injury, or medical condition. If so, state what accident, injury or medical condition, when it occurred, when benefits were applied for or received and what compensation or benefits were applied for or received, and what compensation or benefits were applied for or received?

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6. Have you ever been involved in an automobile or other vehicular accident(s) for which you sought medical treatment or were injured? If so, please provide as to each:

A. When the accident occurred._____

B. Where the accident occurred._____

C. How the accident occurred._____

D. If you were injured, how?_____

E. Was the accident job-related?_____

F. Names, addresses and telephone numbers of all health care providers who treated you.

_____

_____

_____

_____

G. Dates of treatment and course of treatment (specify by whom).

_____

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_____

H. Provide the names, addresses and telephone numbers of all persons who may have knowledge of the injuries resulting from the accident.

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_____

7. Have you ever had a fall, collision, sports injury, accident, etc. for which you sought medical treatment or were injured? If so, please provide as to each:

A. When the incident occurred._____

B. Where the accident occurred._____

C. How the incident occurred._____

D. If you were injured, how?_____

_____

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_____

E. Was the accident job-related?

_____

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_____

_____

F. Names, addresses and telephone numbers of all health care providers who treated you:

_____

_____

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_____

G. Dates of treatment and course of treatment (specify by whom).

_____

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_____

H. Provide the names, addresses and telephone numbers of all persons who may have knowledge of the injuries resulting from the accident.

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8. Provide the name(s), address(es) and telephone number(s) of your family physician and/or primary care provider for the last ten (10) years.

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9. Other than those listed in numbers 3F or 8, list the names, business addresses and telephone numbers of all other physicians, medical facilities or other health care providers by whom or at which you have been examined or treated in the past ten (10) years; and state, as to each, the dates of examination or treatment and the condition or injury for which you were examined or treated.

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10. Has your sworn statement or deposition ever been taken in connection with any claim arising out of the illness or injury for which you seek disability retirement? If so, state the date taken and by whom.

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11. Provide the names, addresses and dates of all of your prior and current employers, including information as to a.): the nature of the work involved with each employment, b.) the status (i.e., terminated, continuing, etc.) of each employment, and c.) the basis or reason for such status.

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12. State whether you are now or ever have been self-employed and, if so, state the name under which you did business, dates and nature of the work.

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13. Please list any extracurricular activities and/or hobbies in which you have participated (ex. sports, bowling, hunting, motorcycle riding, weight lifting/training, running, golf, martial arts, skiing, etc.):

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14. Please provide any other information known to you or your attorney that might be relevant to your application for disability retirement?

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15. State here any other information you want the Pension Board's medical doctor or the Pension Board to consider in making a decision on your application.

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YOU ARE REQUIRED TO SUPPLEMENT THIS QUESTIONNAIRE IMMEDIATELY IN WRITING TO THE PENSION COORDINATOR WITH ANY NEW OR ADDITIONAL INFORMATION OBTAINED BETWEEN THE TIME OF SIGNING THIS QUESTIONNAIRE AND FINAL DECISION BY THE BOARD OF TRUSTEES.

I HEREBY SWEAR OR AFFIRM that the information contained in this application, the supporting application package and any additional information provided to the Board of Trustees is true and correct to the best of my knowledge and I understand that a false statement knowingly made on my application can serve as grounds for denial of my application and, further, that I may be subject to criminal and other penalties for false, fraudulent and/or misleading oral or written statements or withholding or concealing information to obtain any benefit available under the pension plan.

I further understand that the Pension Board and its records are subject to the Florida Public Records Act and the Government in the Sunshine Law and that a hearing on my disability application will, by law, be a public hearing and by submitting my application,

I hereby authorize the Pension Board to conduct a public discussion of my medical condition and records and, further, release the Board of Trustees, their agents, servants and employees from any liability connected therewith.

_____ _____

Date Signature

SWORN TO AND SUBSCRIBED before me this _____day

of_____, 20__.

_____

Notary Public

Personally Known___ or Type of Identification Provided_____

My Commission Expires: