TO: APPLICANTS FOR DISABILITY PENSION

SUBJECT: DISABILITY PENSION APPLICATION REQUIREMENTS

ATTACHED YOU WILL FIND THE FOLLOWING:

1. GUIDELINES AND INFORMATION SHEET FOR APPLICATION FOR DISABILITY PENSION
2. APPLICATION FOR DISABILITY
3. PHYSICIAN'S REPORT FORM
4. AUTHORIZATION TO RELEASE MEDICAL, PSYCHOLOGICAL AND EMPLOYMENT INFORMATION
5. TABLE OF CONTENTS
6. APPLICANT'S CERTIFICATION OF COMPLETION

As noted on the Guidelines and Information Sheet (Item 1), it is incumbent on you, the applicant, to provide all relevant information, which will support your request for a disability pension and to provide such information in a format as directed by the Pension Board of Trustees.

In order to assist you in this process, the above listed documents are being provided. Because these cases require a substantial amount of documents and because the Board of Trustees requires uniformity in the process in order to insure a thorough and fair consideration of all applications, your adherence to these requirements in mandatory; this includes use of the forms provided **without any change or alteration.** Failure to so utilize these forms will result in your application being considered incomplete and unacceptable for presentation to the Board.

Please read the "Guidelines and Information Sheet for Application for Disability Pension" and other attached documents carefully. You must first complete and file the "Application for Disability Pension." Thereafter, you must assemble your "application package" in accordance with the Table of Contents (Item 5) and complete the Applicant's Certification of Completion (Item 6), which in effect advises the Pension Board that you have completed your application process.

The original of the completed "application package" should be placed in a three-ring notebook, in the order following the Table of Contents and including the Applicant's Certification of Completion. **After one completed notebook is finished and pages numbered,** please arrange to meet with the Pension Coordinator to review the contents. The application packet will be reviewed for completeness by the Legal Counsel prior to approval by the Pension Coordinator. Once approved by the Pension Coordinator for completion, please have an electronic copy made of the "application package". Two hard copies of the notebook and two electronic copies must be filed with the Pension Coordinator, Office of Business & Financial Services, 4th floor, Orlando City Hall within thirty (30) calendar days after the date you filed your application. When the Independent Medical Examination (IME) is scheduled you will be notified of the date/time in writing and by telephone. Thereafter, you will be notified of the date/time of the disability hearing before the Board of Trustees.

Received by: _____Applicant Date: _____

Questions: Please contact the Pension Coordinator at 407-246-3410.

ORLANDO FIREFIGHTERS' PENSION BOARD
GUIDELINES AND INFORMATION SHEET
FOR
APPLICATION FOR DISABILITY PENSION

1. Application for Disability Pension, whether line-of-duty or non-line of duty, shall be on the application form provided. ***Each application will be considered and determined by the Pension Board on the application's own merits***.

2. All information must be submitted, and all questions answered, fully and accurately on the form provided.

3. The ***burden is on the applicant*** to provide complete documentation in support of the application -- reports from physician(s) (on the form provided), physicians' office notes, reports of hospitalization and/or surgery, test results, and other **medical information pertaining to the medical/psychiatric/psychological condition for which the disability pension is sought at the applicant's expense.** If the medical condition for which disability pension is sought is tuberculosis, heart disease, hypertension, hepatitis or meningococcal meningitis, please review the provisions of Sections 112.18 and 112.181, Florida Statutes.

4. Guidelines for the supporting documentation ("application package") are as follows:

    a. The application package (and each copy of the package) should be organized in a 3-ring notebook binder, in the order set forth in the Table of Contents (Item 5) in this packet. Each new section should be separated and marked with a tab and EACH PAGE must be consecutively numbered at the top right-hand corner of each page. If no documents exist for a particular section, please provide a statement to that effect under the appropriate Tab number.
    b. Tab 1 – Application for Disability Retirement – your completed and signed application.
    c. Tab 2 –Copy of Initial Accident/Injury Report-First Notice of Injury, DWC1, Fire Report, and Patient Care Reports for each physician in chronological order.
    d. Tab 3 – Physician's Reports with Office Notes (in chronological order) – you should include a Physician's Report for each medical practitioner that treated or examined you for the injury/condition for which the disability pension is sought (with the exception of the City's occupational medical provider's doctors, see Tab 5). Include immediately behind each Report a copy of the ENTIRE medical file (in chronological order) of the medical practitioner, including but not limited to ALL medical records, reports, office notes, treatment plans, test results, etc. It is your responsibility to collect the Physician's Report(s) and other medical documentation and submit them in your application package. **The Physician's Report(s), prepared on the form provided by the City, shall not be dated more than 60 days prior to the date of submission of the application package or the Board will not consider it/them**

evidence. The Report and the medical documentation **should not** be sent directly to the Board, but included in your package.

e. Tab 4 – Hospitalization/Surgical Reports (in chronological order by each physician) – provide a copy of all such documents that pertain to your injury/medical condition for which disability pension is sought.
f. Tab 5 – The City's occupational medical provider will provide a copy of their ENTIRE medical file, including but not limited to ALL medical records, reports, office notes, treatment plans, test results, etc., that pertain to your injury/medical condition for which disability pension is sought.
g. Tab 6 – Diagnostic Reports and Functional Capacity Evaluations (FCE) (in chronological order for each physician or facility) - provide reports of x-rays, MRIs, CT Scans, nerve conduction studies, EEGs, EKGs, etc.; and Functional Capacity Evaluations (FCE) that pertain to your injury/medical condition for which disability pension is sought performed during the last ten (10) years.
h. **Tab 7 (Line of duty ONLY)**– Petitions for Workers' Compensation Benefits from the City's third party workers' compensation company that pertain to your injury/medical condition for which disability pension is sought, any determinations/orders received, and any depositions taken in the workers' compensation proceedings; and any records and reports of any experts involved in the workers' compensation proceedings that pertain to your injury/medical condition for which disability pension is sought NOT previously included in Tab 3, Tab 5 or Tab 6.
i. Tab 8 - Application for Social Security Benefits – with determination if received
j. Tab 9 – Medical records for doctors named in items 8 and 9
k. Tab 10 - Pre-employment physical.
l. Tab 11 – Any other supporting documentation
m. Tab 12–Authorization to Release Medical Information
n. Tab 13- Certification of Completion.
o. Tab 14-Independent Medical Evaluation (IME) – provide a section divider and Tab number for the future IME report.

5. The application package must be submitted within thirty (30) calendar days of the date the application is filed. Two hard copies of the notebook and two electronic copies are required. It is not the responsibility of the Pension Board to secure the information on behalf of the applicant; the applicant has the affirmative obligation to secure and provide all necessary supporting documentation in a timely fashion.

6. Both copies of the~~The~~ completed application package notebook (original paper copy and one (1) electronic copy) in the format mandated by the Pension Board and on the forms provided by the Pension Board shall be filed with the Pension Coordinator, 4th Floor, Orlando City Hall.

7. Upon receipt of the application package notebook, it will be reviewed for completeness by the Fund legal counsel. If it is determined that there are missing records, the notebook will be

returned to the applicant so that the missing information can be added.

8. Each applicant must submit to an Independent Medical Examination (IME) with a medical doctor selected by the Pension Board. An IME cannot be scheduled until the application package notebook is complete.

9. Upon receipt of the IME, an informal hearing will be scheduled. At this informal hearing the Board will review the disability application on the basis of the records only. The applicant is entitled to be present, but no evidence or testimony will be taken at the ~~this~~ informal hearing stage.

10. If the Board finds that there is competent substantial evidence, the application can be granted. If there is insufficient evidence the application will be denied. The Pension Board may require the applicant to submit to further consultations and/or examinations by physicians selected by the Board, with the cost thereof to be borne by the Board. This option, purely at the discretion of the Board, shall not be construed to relieve the applicant from the burden of providing sufficient evidence in support of the application. If the application is denied, the member has a right to appeal the decision to the Board for a formal hearing.

11. The formal hearing must be requested within 20 days of the receipt of the order. At the formal hearing, the Board will consider evidence and testimony.

12. Discovery in Preparation for Formal Hearing:
a. Depositions may be taken, upon proper notice to the parties, in accordance with the format in Rule 1.310 of the Florida Rules of Civil Procedure. Testimony for the hearing may be submitted in the form of a deposition that was properly noticed. The Board prefers that testimony by deposition be submitted in advance in order to give the Board more time for review and consideration.

b. Any additional, requests for medical records, past or present employment records or workers compensation records, and notices of depositions shall be in writing with a copy to the other party (Applicant or Applicant's Counsel, Fire Department's Counsel c/o City Attorney's Office, City of Orlando) with a copy to the Pension Coordinator, 4th floor, Orlando City Hall.

13. The Pension Board will generally schedule a hearing on the application upon agreement of the applicant (or applicant's counsel) and the Fire Department's counsel, but such hearing shall be scheduled within sixty (60) calendar days after receipt of the IME report by the applicant (or applicant's counsel) and Fire Department's counsel. The hearing will proceed unless a continuance is requested upon good cause shown to the Board of Trustees and the Board, upon majority vote, continues the hearing to a later date or the Board, in its own discretion, continues the hearing to a later date.

14. The applicant is entitled to be represented by legal counsel of applicant's choosing, and at applicant's expense, in the presentation of the application for disability retirement. If the applicant is to be represented by legal counsel, such attorney must file a Notice of Appearance with the Pension Coordinator, 4th Floor, Orlando City Hall with a copy of such notice to the Fire Department's Counsel c/o City Attorney's Office, City of Orlando. The Fire Department is also entitled to be represented by legal counsel or a departmental advocate to represent the interests of the Department during the application process and at the hearing.

15. The applicant will appear at the hearing in person, unless excused by the Board. The Board may take testimony, under oath, from the applicant, from the Department representatives, and other witnesses and may consider any other evidence, which is relevant. The applicant shall be responsible for ensuring the appearance of witnesses at the hearing. Such witnesses are subject to examination and cross-examination by legal counsel for the applicant and the Department. Members of the Board and the Board's legal counsel shall also be entitled to ask questions of the witnesses.

16. The Board shall determine, based upon competent substantial evidence whether the applicant has proven by a preponderance of the evidence, the member's entitlement to a disability pension. Entitlement shall be based on the provisions governing the pension fund.

17. The hearing is a formal, quasi-judicial proceeding. The strict adherence to the rules of procedure and evidence shall not be required. The Board, by majority vote, may grant the request as presented, deny the request as presented, or grant a type of disability retirement other than as requested, or take any other action in accordance with state and local laws.

18. If the Board denies the applicant a pension, the applicant may seek review by way of certiorari in the Ninth Judicial Circuit Court.

19. If the disability retirement is granted, the Board shall specify the date on which such retirement is effective and shall direct Employee Benefits to make the necessary computation of monthly benefits and shall authorize the Accounting Department to make disbursements accordingly. The Board at the next regular meeting following its decision granting retirement shall confirm said computation.

Questions concerning the application process may be directed to the Pension Coordinator - (407-246-3410)

400 SOUTH ORANGE AVENUE
P.O. BOX 4990
ORLANDO, FLORIDA 32802-4990
TELEPHONE (407) 246-3410

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_____

Social Security # _____ Date of Birth:_____
(see attached language)
Date of Hire _____ Current Assignment_____

Status of Employment _____

Home Address_____

_____

Home Telephone _____ Work Telephone _____

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."

In accordance with the provisions of §119.071(5)(a)6g, Florida Statutes, the collection and use of social security numbers is authorized for the purpose of the administration of the pension fund. This information will not become public record.

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:

_____

_____

_____

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

_____

_____

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 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._____

_____

_____

_____

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

_____

_____

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

_____

_____

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

_____

_____

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)._____

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._____

_____

_____

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? _____

_____

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

_____

_____

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?

_____

_____

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?

_____

_____

_____

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)._____

_____
_____

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

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 incident occurred._____
C. How the incident occurred._____
D. If you were injured, how?_____
E. Names, addresses and telephone numbers of all health care providers who treated you._____
_____
_____

F. Dates of treatment and course of treatment (specify by whom).
_____
_____

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

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.
_____

_____

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._____

_____

_____

_____

_____

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._____

_____

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._____

_____

_____

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.

_____

_____

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.):

_____

_____

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

_____

_____

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_____

_____

_____

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:

400 S. Orange Avenue
P.O. BOX 4990
Orlando, FL 32802-4990
Telephone
(407) 246-3410

PHYSICIAN'S REPORT

Date _____

MEDICAL/DISABILITY RETIREMENT APPLICATION OF _____

The above referenced individual has applied to the Pension Board for a disability pension. This is a separate and distinct process from a workers' compensation claim. The Board requires specific answers to the following questions in order to render a fair and equitable decision on this application. Your cooperation in **thoroughly** answering these questions is appreciated.

If further space is required for any question, please attach additional pages, indicating the question number to which the information applies.

The information requested herein should be furnished **directly to the applicant** (who, in turn, will be assembling an application "package" for presentation to the Board). Please **do not** send this Physician's Report to the Pension Board.

1. What is the injury/condition for which you saw and/or treated the applicant? Explain fully. _____

_____

_____

2. Is the current condition permanent or temporary? Explain fully. _____

_____

_____

3. Is the condition degenerative? Explain fully. _____

_____

_____

4. What disability/impairment rating would you assign this medical condition (percentage of the body as a whole)?

_____

_____

5. Is the condition/disability partial or total? Explainfully. _____

_____

6. What is the applicant's current medical status? _____

_____

7. If condition or disability is PTSD or similar psychological or psychiatric health issue, please detail the DSM V criteria as follows:

   a. Stressor_____

   _____

   b. Intrusion symptoms_____

   _____

   c. Avoidance_____

   _____

   d. Negative alterations in cognitions and mood_____

   _____

   e. Alteration in arousal and reactivity_____

   _____

   f. Duration_____

   _____

   g. Functional significance_____

   _____

h. Exclusions_____

_____

i. Specifications_____

_____

NOTE: With reference to Questions 8 through 11, please review and consider the attached Job Description.

8. a. Can the condition be controlled and/or cured by the use of medication? (If YES, specify "control" or "cure", the medication, and any known side effects of such medication). Explain fully. _____

_____

_____

b. If yes, can the condition be so controlled and/or cured to the extent that the applicant can perform his/her duties as a firefighter? Explain fully._____

_____

_____

9. a. Can the condition be controlled and/or cured by surgery? (If YES, specify "control" or "cure" and the nature of the surgery.) Explain fully._____

_____

_____

b. If yes, can the condition be controlled and/or cured to the extent that the applicant can perform his/her duties as a firefighter? Explain fully._____

_____

_____

10. a. Can the condition be controlled and/or cured by means other than medication or surgery (i.e., exercise, weight control, stop smoking, diet, counseling, etc.)? Explain fully. _____

_____

_____

b. If yes, can the condition be controlled and/or cured to the extent that the applicant can perform his/her duties as a firefighter? Explain fully. _____

_____

11. In light of the present condition, what restrictions (if any) would you impose on the individual's activities, including continued employment as a firefighter (see job description)? _____

_____

_____

12. Does the medical condition render the member unfit to perform the required duties of the member's rank? _____

_____

_____

13. Do you have any personal knowledge OR a professional medical opinion as to whether the disability is directly caused by and attributable to the performance of duty as a member of the Fire Department? Explain fully. _____

_____

_____

14. Is the condition for which you saw and/or treated applicant related to/the result of/caused by any other medical condition, including because of or due to the aggravation of a specific injury, impairment or other medical condition pre-existing the member's employment with the Fire Department? Explain fully. _____

_____

_____

15. Is the present condition related to/the result of/caused by any congenital or childhood (prior to age 18) medical condition? Explain fully. _____

_____

_____

16. If a condition pre-existing at the time of employment exists, is the applicant's current medical condition solely attributable to the occupational injury? Explain fully._____

_____

17. What medication or other treatment is presently being prescribed? Explain fully:

_____

18. In your professional medical opinion, has the applicant adequately performed all of the recommended Treatments or the therapies to be able to perform their job duties?

_____

_____

19. How long has the individual been under your care, for this or any other condition?

_____

20. In what particular "specialty" area of medicine do you practice and are you Board Certified?

_____

_____

In addition, the Pension Board will need copies of any and all test results, reports of hospitalization and/or surgery, office notes, and any other reports in your chart concerning this individual which should be requested by the applicant to be provided to the Board.

The information requested herein should be furnished **directly to the applicant** (who, in turn, will be assembling an application "package" for presentation to the Board). Please do not send this Physician's Report to the Board.

Thank you for your cooperation.

Jason R. Franklin
Chairman
Orlando Firefighters' Pension Board

_____
Physician Signature

_____
Typed or Printed Name of Physician

_____
Date

Attachment: Firefighter-Job Description
Presumption Status if necessary

DISABILITY PENSION APPLICATION PACKAGE

TABLE OF CONTENTS

**NOTE: EACH PAGE must be consecutively numbered at the top right-hand corner of each page.

ORLANDO FIREFIGHTERS' PENSION BOARD
TELEPHONE (407) 246-3410

400 S. ORANGE AVENUE
P.O. BOX 4990
ORLANDO, FL 32802-4990

AUTHORIZATION TO RELEASE MEDICAL, PSYCHOLOGICAL AND EMPLOYMENT INFORMATION

(including PROTECTED HEALTH INFORMATION)

I, _____,hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider or other person who has attended, examined, or furnished medical services to me ("My Providers") to disclose my entire medical record and any other protected health information concerning me to:

the Orlando Firefighter's Pension Board, or their authorized representatives (including Florida Hospital and Florida Hospital Centra Care), and any medical provider to whom I am referred for an Independent Medical Examination.

The protected health information authorized for release is as follows:
any and all information with respect to any illness or injury, medical history, diagnosis, consultation, prescriptions, or treatments and copies of all hospital or medical records pertaining thereto, including but not limited to intake questionnaires, reports, x-rays, diagnostic tests, films, charts, and other documents of every kind and description including psychiatric reports and/or evaluations and drug or alcohol use information.

I further hereby authorize full and complete disclosure of the records of educational institutions, military agencies/units, U.S.Veteran's Administration, current and former employers or any other person to furnish complete copies of all records of every kind or nature, including but not limited to reports, findings, charts, documents, x-rays, diagnostic tests, films and evaluations, concerning my medical history, diagnosis, treatment or care, and my employment.

The protected health information to be disclosed under this authorization is for the purpose of: This information for which I am authorizing disclosure will be used for the following purpose: To facilitate the Board of Trustees of the Fund in the carrying out its duty to review, discuss and determine my application for disability retirement. I hereby waive the right of confidentiality of medical/health records and other medical evidence in the custody of the Board of Trustees or elsewhere. I further understand that such records will be discussed during one or more public meetings and will become public record. I understand that the Board of Trustees will rely upon this waiver.

This authorization will expire at the end of my disability case before the Board. I understand that I have the right to revoke this authorization, in writing. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this authorization to disclose information about me. I further understand that if I refuse to sign this authorization to release my complete medical records or revoke this authorization, my application for disability pension will not be able to be processed and may result in adverse employment consequences.

I understand that a refusal to sign this authorization will not result in a denial of health care by My Providers.
I further understand that once the protected health information is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal HIPAA privacy regulations.

A copy of this executed authorization shall be considered as effective and valid as the original.

I HAVE FULLY READ AND UNDERSTAND THIS AUTHORIZATION FOR RELEASE OF INFORMATION.

_____	_____
NAME OF PATIENT (Print)	DATE

_____	_____	_____
NAME OF PATIENT (Signature)	PATIENT'S SSN (Last 4 digits)	DATE OF BIRTH

_____	_____
NAME OF WITNESS (Print)	NAME OF WITNESS (Signature)

APPLICANT'S CERTIFICATION OF COMPLETION

I, _____, hereby
(Print or Type Name)
certify that I have been made aware of the requirements for filing an Application for Disability Pension, have been furnished all required forms, have completed all such forms which I am required to complete, and have secured all medical documentation pertaining to my application.

I hereby certify that all records obtained by me have been included in this application package.

I also hereby certify that I have not made any false, fraudulent or misleading written statements and I have not withheld or concealed material information to obtain any disability benefit available under my retirement plan.

Accordingly, I hereby certify that my application package is complete and that I have furnished the original plus the required number of copies (2) of said application package to the Pension Coordinator, 4th Floor, Orlando City Hall.

_____
Signature of Applicant

_____
Employee Number

_____
Date