

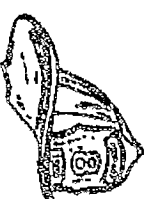


FIREFIGHTERS' RETIREMENT SYSTEM

P.O. Box 94095, Capitol Station
Baton Rouge, Louisiana 70804-9095

Telephone (225) 925-4060

Fax (225) 925-4062



APPLICATION FOR DISABILITY RETIREMENT

INSTRUCTIONS: COMPLETE ALL SECTIONS OF THIS APPLICATION AND RETURN ALONG WITH COMPLETE AND DETAILED MEDICAL RECORDS PERTAINING TO THE CLAIMED DISABILITY. RETURN TO FIREFIGHTERS' RETIREMENT SYSTEM AT LEAST 60 DAYS PRIOR TO TERMINATION DATE. ALL APPLICANTS ARE REQUIRED TO UNDERGO AN EXAMINATION BY A PHYSICIAN ON THE STATE MEDICAL DIABILITY BOARD. * SEE BACK OF FORM *****

Applicant's Name		Social Security Number	
and		Birth Date	
1 Address		Telephone No. ()	
Spouse's Name		Social Security Number	
2 and		Birth Date	
Address		Doctor's Telephone Number	
3 Applicant's Doctor's Name			
Complete the following in your own words. I am disabled from performing my job duties because:			
Do you consider this disability to be job related?		Are you receiving workmen's compensation?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
4 Name of workmen's compensation insurance company and telephone number		Weekly amount of workmen's compensation \$	
Area Code ()			
If you are not receiving workmen's compensation, have you applied for it? If not, why?			
I hereby acknowledge that my FRS disability benefit WILL be reduced if I receive workmen's compensation, or any other form of income. _____ (Initial Here)			
AGENCY CERTIFICATION			
Applicant's Job Classification (Include copy of applicant's job description)		Degree of physical exertion required	
How long has the applicant been unable to perform the duties of his position?			
List the job duties which the applicant is no longer able to perform:			
5 Provide any specific information you know about the date and cause of the applicant's accident/injury:			
Was the applicant on duty at the time of the accident/injury?		Do you consider this accident/injury to be job-related?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Attach a copy of the applicant's official job description and a copy of the Employer's Report of Occupational Injury or Disease to this application.			
Employing Agency		Date on which applicant exhausted all sick & annual leave	
Fire Chief's Signature		Immediate Supervisor's Signature if other than the Fire Chief	

****Please attach a copy of all medical records pertaining to claimed disability****

Applicant's Signature

Date

SEE BACK OF FORM

AFFIDAVIT

NOTE: TO BE COMPLETED AND SIGNED BEFORE A NOTARY:

State of _____ Parish of _____

BEFORE ME, the undersigned authority, personally came and appeared _____, who upon being first duly sworn, did depose and state that he/she has certified that he/she has provided all medical records related to his/her claimed disability as well as any preexisting conditions he/she has whether or not disclosed on his/her enrollment application. Subject to the provisions of R.S. 11:2266.

Signature of Retiree

SWORN TO AND SUBSCRIBED BEFORE ME, Notary Public in and for the parish/county and state aforesaid, his _____ day of _____, year of _____.

NOTARY PUBLIC

PLEASE READ:

Any applicant who (1) makes any false statement or who falsifies any record(s) in an attempt to defraud the system, and/or (2) fails to provide full and complete medical evidence of physical condition, or of any preexisting medical conditions when submitting a disability application will be subject to penalties under R.S. 11:2266.