

Florida Retirement System
Statement of Disability by Employer

PO BOX 9000 Tallahassee, FL 32315-9000
Local Phone: 850-907-6500 Toll Free: 844-377-1888 FAX: 850-410-2010



Applicant Name

Applicant SSN

Position Title

This form should be completed and signed by the designated person in your personnel office.

Date of Employment _____

Agency Name _____

Last Day Worked _____

Last Day in Pay Status _____

Termination Date _____

Was the applicant able to perform all duties of this position prior to the illness or injury?

Yes ___ No ___

If not, please explain _____

Has the applicant discussed with your personnel office the possibility of moving into another position with your agency which would be within the applicant's medical limitations? Yes ___ No ___

If so, what positions were identified? _____

Why was this position not accepted? _____

Type of disability: Regular In-Line-of-Duty

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If the applicant is applying for **in-line-of-duty** disability retirement please provide:

- (1) A copy of the pre-employment physical examination, if any.
- (2) Copies of all First Report of Injury or Notice of Injury Forms filed with Workers' Compensation or Risk Management.
- (3) Copies of any Orders signed by a Deputy Commissioner, Rehabilitation Reports and medical documentation relative to the applicant's claim for in-line-of-duty disability.

Comments: _____

Authorized Signature: _____

Date: _____

Name (print): _____

Address: _____

Office Location

Title: _____

Phone: _____
