

**Florida Retirement System  
Physician's Report**

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 \_\_\_\_\_ Employer \_\_\_\_\_

**Check One:**

Regular Disability: \_\_\_\_\_ Florida Statutes, Chapter 121.091(4)(b), Total and permanent disability. "A member shall be considered totally and permanently disabled if, in the opinion of the administrator, he is prevented, by reason of a medically determinable physical or mental impairment, from rendering useful and efficient service as an officer or employee."

In-Line-Of-Duty Disability: \_\_\_\_\_ Florida Statutes, Chapter 121.021(13), "Disability in line of duty means an injury or illness arising out of and in the actual performance of duty required by a member's employment during regularly scheduled working hours or irregular working hours as required by the employer . . ."

**Authorization for release of medical information**

I authorize my physician to release any information recorded on the examination report and any other pertinent facts and documents concerning my condition to the Florida Retirement System.

\_\_\_\_\_  
Applicant Signature Date

**Physician's Statement**

The patient is responsible for completion of this form without expense to the State of Florida. Please provide any additional information and copies of your office notes, if you feel they are pertinent to an understanding of this patient's condition. However, office notes CANNOT be submitted in lieu of properly completing page two of this form.

License Number \_\_\_\_\_  
Issued By Florida Board of Medical Examiners Physician's Name (Please print) \_\_\_\_\_

Specialty \_\_\_\_\_ Address \_\_\_\_\_  
Fax \_\_\_\_\_  
Phone \_\_\_\_\_

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Physician's Report**

Applicant Name: \_\_\_\_\_ Applicant SSN: \_\_\_\_\_

**1. Diagnosis:**

- a) When did you first treat this patient? Date: \_\_\_\_\_
- b) Date of most recent examination: \_\_\_\_\_
- c) Primary disabling condition: \_\_\_\_\_  
\_\_\_\_\_
- d) Secondary condition(s): \_\_\_\_\_  
\_\_\_\_\_
- e) What restrictions have you placed on the patient's activities? \_\_\_\_\_

**2. Prognosis:**

- a) Has the patient's condition stabilized? Yes \_\_\_\_\_ No \_\_\_\_\_
- b) Has the patient reached maximum medical improvement? Yes \_\_\_\_\_ No \_\_\_\_\_
- c) If so, when did the patient reach maximum medical improvement? Date \_\_\_\_\_
- d) Is the patient a candidate for vocational rehabilitation? Yes \_\_\_\_\_ No \_\_\_\_\_
- e) Additional comments: \_\_\_\_\_

**3. Physical and/or Mental Impairment:**

- \_\_\_\_\_ No limitation of functional capacity; may return to work.
- \_\_\_\_\_ Slight limitation of functional capacity; capable of light work.
- \_\_\_\_\_ Moderate limitation of functional capacity; capable of sedentary work.
- \_\_\_\_\_ Cannot perform present work, but capable of performing another line of work.
- \_\_\_\_\_ Temporary limitation of functional capacity; temporarily incapable of any kind of work; temporarily disabled from gainful employment.
- \_\_\_\_\_ Limitation of functional capacity to the extent that the member is permanently prevented by reason of a medically determinable physical or mental impairment from rendering useful and efficient service as an officer or employee.

**4. In-Line-Of-Duty:** (Complete only if "in-line-of-duty" disability retirement was checked on opposite page and injury arose out of the performance of duty. All four questions must be answered.)

- a) Is the patient's primary disability due to an on-the-job injury or illness? \_\_\_\_\_
- b) If so, what was the date of the injury? \_\_\_\_\_
- c) How do you relate the primary disability to the on-the-job injury? \_\_\_\_\_
- d) Is there any cause other than the on-the-job injury contributing to the patient's disability? Please explain: \_\_\_\_\_  
\_\_\_\_\_

**Additional Comments:** \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Physician's Name (Please Print)

\_\_\_\_\_  
Date