The City of Miramar
Police Officers’ Retirement Plan and Trust Fund

DISABILITY RETIREMENT
APPLICATION ACKNOWLEDGEMENT

This is to certify that I have received the following documents, in addition to this letter, for the purpose of applying for a disability retirement:

1. Application for Disability Retirement Benefits
2. Release for medical information
3. Physician report forms
4. Statement of disability by the employer
5. Request for reasonable accommodation under the Americans With Disabilities Act

I understand that the above listed forms and documents must be completed in their entirety and returned to the retirement office before my application can be processed.

I also understand that I have the right to appeal a denial decision and may request a copy of the proceedings (as stipulated in Florida Statute 286.0105) which includes the testimony and evidence upon which the appeal is to be based.

Applicant - Print Name

Applicant’s Signature
APPLICATION FOR DISABILITY RETIREMENT

Date: ______________________

Name: _____________________________________________________________

Social Security No.: _________________________________________________

Department Name: _________________________________________________

Job Title: __________________________________________________________

Date of Employment (mm/dd/yyyy): _________________________________

Date of Entry into Pension Plan (mm/dd/yyyy): _________________________

All questions must be completed before the Trustees of the Pension Plan will consider your application. If further space is required on any question, attach additional pages indicating the item to which the information applies:

1. Have you asked your employer to make a reasonable accommodation for you within your limitations, as defined by the Americans With Disabilities Act? (Documentation of this inquiry and the response must be attached)

   YES _________  NO _________

2. Do you currently have any disciplinary action pending against you? If yes, please explain.

   YES _________  NO _________

   ________________________________________________________________

   ________________________________________________________________

3. Describe the illness or injury which has caused your disability.

   ________________________________________________________________

   ________________________________________________________________

   ________________________________________________________________
4. List the names and addresses of all physicians, hospitals, rehabilitation facilities, or any other person who has provided medical treatment in connection with your disability.


5. Has any physician restricted your activities?

YES ________  NO ________

If yes, please describe the restrictions. ______________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

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

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
7. If you have ever been injured for any reason requiring medical treatment prior to this date, list the date of the injury, cause, treatment you received, name the physician attending you, hospital or clinic where treatment was performed, the date of recovery, and any present disability resulting therefrom.

8. While you were injured, did you receive any disability benefits from your employer? If the answer is yes, please identify the date benefits commenced and the date benefits terminated.

YES _______  NO _______

9. If you have any other physical impairment(s), please describe them and the length of time they have existed.
I hereby apply for a disability retirement and I affirm that all the informational statements contained herein are true and correct to the best of my knowledge. I understand that a false statement knowingly made on my application can serve as grounds for denial of my application.

Print Name

Signature

Telephone

Social Security No.

Street Address

City/State/Zip Code
The City of Miramar
Police Officers’ Retirement Plan and Trust Fund

RELEASE OF MEDICAL INFORMATION

The undersigned applicant for disability retirement from the City of Miramar Police Officers’ Retirement Plan and Trust hereby authorizes the Board of Trustees, its agents, servants, and employees to receive any and all reports, x-rays, charts, documents of every kind and description, including psychiatric reports, evaluations, and information relating to my medical condition. This form shall also serve as authorization for any treating physician, hospital, former employer, health care provider, or any other person to furnish to the Board of Trustees originals or complete copies of all records, reports, findings, charts, documents, x-rays, of every kind and description, concerning my treatment and care.

I further understand and authorize the Board of Trustees or any person acting on their behalf to include any discussion of this medical information in its official records and understand that should my medical condition ever become an issue regarding approval or denial of disability retirement, that said information may become the subject of a public discussion at a meeting governed by the Government in the Sunshine Law and/or a public record governed by the Florida Public Records Act.

I agree, as a condition of application for disability retirement, to the utilization of that information as described and release the Pension Plan, the Board of Trustees, their agents, servants and employees from any liability connected with the utilization of those medical records as described in this form.

A photocopy of an executed form shall have the same force and effect as an original.

__________________________________________
Applicant - Print Name

__________________________________________
Applicant’s Signature

__________________________________________
Date
PHYSICIAN REPORT FORM

Name of physician: _____________________________________________________________

Address:  _____________________________________________________________________

____________________________________________________________________________

Telephone: ____________________________________________________________________

Area of specialization: _________________________________________________________

Board certification, if any: ____________________________________________________

Florida Medical License No.: ________________________________________________

I examined ___________________________________________ (name of applicant) in connection with his application for a disability retirement. The results of my examination are attached. (Attach narrative)

Description of medical condition: ______________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Cause/origin of condition: _____________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________
On the basis of the attached findings, it is my opinion that the applicant:

1. Is/is not permanently disabled (circle appropriate response) from regular and continuous duty as a police officer.

If the applicant is not permanently disabled, explain:______________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

2. The applicant is/is not totally disabled (circle appropriate response) from regular and continuous duty as a police officer.

If the applicant is not totally disabled, explain:_______________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

3. The illness or injury giving rise to the disability did/did not occur in the course and scope of the employee’s duties with the Miramar Police Department (circle appropriate response).

If the illness of injury is not service connected, please explain:

____________________________________________________________________________

\[1\] Disabilities resulting from heart disease, hypertension, and tuberculosis are presumed to be job related under Fla.Stat. §185.34; disabilities resulting from hepatitis, meningococcal meningitis and tuberculosis are presumed to be job related under Fla.Stat. §112.181.
STATEMENT OF DISABILITY BY EMPLOYER

Employee’s Name: ________________________________

Social Security No.: ________________________________

Department: ________________________________

Date of hire: ________________________________

Employee has or will terminate upon: ________________________________

Our office has been notified that this employee is applying for a disability retirement for the following reason:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Present job title and assignment: ________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Was the employee prior to his/her alleged disability, able to perform all of the duties of the position fully and completely? If not, list those duties which could not be performed.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Does the employee’s alleged disability prevent the performance of any of his or her current duties? If so, how does the disability affect his or her performance?

_________________________________________________________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________________________________________________________

How many days has the employee been absent from work this year?

_________________________________________________________________________________________________________________________________________________________________

What percentage of this absence is directly related to the present alleged disability? ________________________________

What other jobs exist that this employee could perform despite his/her alleged disability?

_________________________________________________________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________________________________________________________

If there are other jobs which the employee can perform, has one been offered?

_________________________________________________________________________________________________________________________________________________________________

If another job has been offered, why was it not accepted?

_________________________________________________________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________________________________________________________
If you regularly evaluate your employees, attach a copy of the last performance evaluation prior to the date of the alleged injury or illness resulting in disability.

What other comments would you make concerning this employee’s condition as it relates to his/her continued or restructured employment?

Print Name

Signature

Official Position

Date
REASONABLE ACCOMMODATION REQUEST FORM

TO: HUMAN RESOURCES DEPARTMENT
    CITY OF MIRAMAR

FROM: ________________________________

I hereby request a reasonable accommodation as follows:

1. **Current job title:** ________________________________
   ________________________________

2. **Department or Division:** ________________________________

3. **Immediate supervisor:** ________________________________

4. **Describe your disability:** ________________________________
   ________________________________
   ________________________________
   ________________________________
   ________________________________
   ________________________________

5. **Describe your current job duties:** ________________________________
   ________________________________
   ________________________________
6. Describe job duties or tasks you are unable to perform due to your disability:

   
   
   
   
   
   
   
   

7. Describe the accommodation you believe would help you perform your job duties:

   
   
   
   
   
   
   
   

Name - Print

Signature

Date: ___________________________