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** ***

1	Applicant's Name	Social Security Number
	and Address	Birth Date
		Telephone No. ( )
2	Spouse's Name	Social Security Number
	and Address	Birth Date
3	Applicant's Doctor's Name	Doctor's Telephone Number

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? ❑ Yes ❑ No	Are you receiving workmen's compensation? ❑ Yes ❑ No	Weekly amount of workmen's compensation. $

4 Name of workmen's compensation insurance company and telephone number
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)**

How long has the applicant been unable to perform the duties of his position?	Degree of physical exertion required

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? ❑Yes ❑ No	Do you consider this accident/injury to be job-related? ❑Yes ❑ No

Attach a copy of the applicant's official job description and a copy of he 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	Date

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

_____ _____
Applicant's Signature Date

*****SEE BACK OF FORM*****

AFFIDAVIT

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 provided all medical records related to his/her claimed disability. 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, this_____ day of _____, year of _____.

_____
NOTARY PUBLIC