FIREFIGHTERS' RETIREMENT SYSTEM

3100 Brentwood Drive
Baton Rouge, Louisiana 70809
Telephone (225) 925-4060 • Fax (225) 925-4062

POST EMPLOYMENT

RETIREMENT SYSTEM ENROLLMENT/MEDICAL INFORMATION

PART A

ENROLLMENT INFORMATION

Please print. All information is to be filled in by the applicant

Name ______________________________________

Social Security # ______________________________

Home Address _________________________________

____

Home Telephone (_____)________________________

Driver's License # ______________________________

Employer ____________________________________

Sex Male_____________ Female_______

Date of Birth __________________________________

Married _________ Single __________ Divorced_______

Job class_____________________________________

DESIGNATION OF BENEFICIARY: I hereby designate ____
whose address is ____, date of birth is ______________
social security number is ____________________________________, and whose relationship to me is that of __________
as the beneficiary to whom I request the Firefighters' Retirement System to Pay, in the event of my death before retirement, the amount of the accumulated contributions or death benefit, if any, standing to my credit in the System.

I hereby authorize the Board of Trustees of the Firefighters' Retirement System to make payment to the beneficiary whom I have above nominated and agree on behalf of myself and my heirs and assigns that payment so made shall be a complete discharge of the claim and shall constitute a release of the System from any further obligation on account of the benefit. I hereby direct that should I survive the aforementioned beneficiary, the amount which otherwise would have been payable to the beneficiary shall be paid to my estate, or to such other beneficiary as I shall hereafter nominate by written designation filed with the Board of Trustees of the Firefighters' Retirement System in accordance with all applicable laws, rules and policies.

SERVICE CREDIT ESTABLISHED IN ANOTHER RETIREMENT SYSTEM OR SYSTEMS
(Show all breaks in service but do not show military service)

PERIOD OF SERVICE						NAME OF RETIREMENT SYSTEM
FROM			TO			
Month	Day	Year	Month	Day	Year	

PRIOR MEMBERSHIP/RETIREMENT HISTORY

Have you ever been a member of the Firefighters' Retirement System? __________ Yes __________ No

Prior membership dates (approx.): From _____________ To _______________ Prior refund date if applicable ___________

Have you ever opted out of the Firefighters' Retirement System because you were also enrolled in social security?

_______ Yes ________ No

Prior membership dates (approx): From _______________ To ________________ Prior refund date if applicable _________

Are you retired and receiving a benefit from another public retirement system? _____Yes _______No

If yes, give the date of retirement ________________ and name of retirement system_____________________________

THE FOLLOWING CERTIFICATE MUST BE COMPLETED BY THE APPLICANT AND NOTARIZED

I certify that all information which I provided is accurate and complete. I understand that any misrepresentation or failure on my part, intentional or unintentional, to fully disclose any information may be grounds for disqualification from and denial of disability benefits from the Firefighters' Retirement System of Louisiana.

I agree to all examinations and tests deemed necessary and authorize any medical information obtained to be furnished to the Firefighters' Retirement System of Louisiana

Signature: ____ Date: ____________________________

Sworn to and subscribed before me this ______________________ day of ____

Notary Public: __________________________________

CERTIFICATION OF EMPLOYMENT: ONLY FULL TIME EMPLOYMENT

THIS IS TO CERTIFY THAT ____ SOCIAL SEC. NO. ____________________
WAS EMPLOYED BY ____ AS A FULL TIME EMPLOYEE ON ________________ 20________ AND IS EARNING AT LEAST $375.00 PER MONTH, EXCLUDING ANY STATE SUPPLEMENT PAY. IN ADDITION, THE EMPLOYEE MUST WORK AN AVERAGE OF 35 HOURS A WEEK OR MORE IN A REPORTING MONTH. THE EFFECTIVE DATE OF MEMBERSHIP WILL BE ____________________, 20______.
THIS ALSO CERTIFIES THAT THE EMPLOYEE NAMED ABOVE WAS GIVEN A PHYSICAL EVALAUTION THAT MEETS OR EXCEEDS THE NATIONAL FIRE PROTECTION ASSOCIATION CODE 1582 STANDARDS.
THE INFORMATION ON THIS FORM MUST BE CERTIFIED BY THE APPOINTING AUTHORITY.

_______________________________________ FIRE CHIEF

_______________________________________ MAYOR, PARISH PRESIDENT or CHAIRMAN OF THE FIRE BOARD

THE FOLLOWING INFORMATION MUST BE COMPLETED BY THE APPLICANT

FAMILY HISTORY - mark an X in the boxes to indication illnesses of family members and death where appropriate. Use space provided to explain items checked

	Cause of death				Tuberculosis	Stroke	Stomach illness	Sickle cell anemia	Rheumatism/ Arthritis	Nervous trouble	Muscular dystrophy	Migraines	Liver trouble	Kidney/bladder trouble	Heart trouble	Hearing trouble	Eye disease	Epilepsy	Diabetes	Cancer/tumor	Blood pressure	Anemia	Allergies/Asthma
	Other causes	Cancer	Heart disease	Age at death																			
Father																							
Mother																							
Blood relative																							

YOUR HEALTH HISTORY - Mark an X in the space next to any of the following you now have or have ever had.
USE THE SPACE PROVIDED BELOW TO EXPLAIN ALL ITEMS CHECKED IN HEALTH AND MENTAL HISTORY. GIVE COMPLETE DETAILS INCLUDING ANY ILLNESSES, ACCIDENTS, OR INJURIES

___ Allergies
___ Amnesia
___ Anemia
___ Arthritis
___ Asthma
___ Back Injury
___ Back pain w/out injury
___ Benign tumor
___ Bladder trouble
___ Bleed easily
___ Blood pressure problems
___ Bronchitis
___ Cancer
___ Carpal tunnel syndrome
___ Diabetes
___ Diphtheria
___ Emphysema
___ Epilepsy
___ Encephalitis

___ Eye Disease
___ Eye injury
___ Head injury (indicate type below)
___ Hearing trouble
___ Heart trouble
___ Hematuria
___ Hepatitis
___ HIV (AIDS)
___ Infantile paralysis
___ Injury
___ Kidney trouble
___ Liver trouble
___ Lung trouble
___ Malaria
___ Migraine headaches
___ Multiple Sclerosis
___ Muscular Dystrophy
___ Muscular weakness
___ Paralysis of a body part

___ Osteomyelitis
___ Positive TB test
___ Rheumatic fever
___ Scarlet Fever
___ Sciatica
___ Seizures
___ Sickle Cell Anemia
___ Skin sores
___ Spinal Meningitis
___ Stomach trouble
___ Stomach ulcer
___ Stroke
___ Surgery
___ Thyroid trouble
___ TMJ trouble
___ Tuberculosis
___ Typhoid Fever
___ Venereal Disease (Indicate type below)

Explanation:

____

____

____

____

Examining Physician's Initials____________ Applicant's Initials____________

MENTAL HEALTH - Have you ever been treated for: Mark X in the space to indicate yes.

_________ Depression _________ Nervousness _________ Schizophrenia
_________ Insomnia _________ Paranoia _________ Stress

DATES	PHYSICIAN	REASON/CAUSE	TREATMENT RECEIVED	OUTCOME

FAMILY PHYSICIAN - Include name, address, phone number of physician(s) for the last 10 years.

HAVE YOU EVER BEEN: Mark X in the space to indicate yes.
Rejected/discharged for medical reasons for:
_________ Military Service? _________ Insurance policy or rated?
_________ Employment?

EXPLAIN ANY ITEMS CHECKED____

HAVE YOU EVER MADE A WORK RELATED CLAIM? _________ Yes _________ No
If yes, give date and explain fully____

HAVE YOU HAD OR ARE YOU EXPERIENCING ANY OF THE FOLLOWING? Mark X in the appropriate space.

Now Past GENERAL:
1.) Gained weight recently? ____ lbs.
2.) Lost weight recently? ____ lbs
___ ___ 3.) On a specialist diet
___ ___ 4.) Lost interest in eating
___ ___ 4.) Seem to be hungry often
___ ___ 6.) More thirsty that usual
___ ___ 7.) Told too much sugar in system
___ ___ 8.) Tendency to be too hot or too cold
___ ___ 9.) Have fever or chills
___ ___ 10.) Feel exhausted or tired most of the time
___ ___ 11.) Difficulty falling or staying asleep

SKIN:
___ ___ 12.) Psoriasis, acne, eczema or other skin trouble
___ ___ 13.) Sores that won't heal
___ ___ 14.) X-ray treatment for skin or in neck area
15.) Skin rash due to:
___ ___ Soap, detergent
___ ___ Toiletries, Cosmetics
___ ___ Poison ivy or oak
___ ___ Sunlight
___ ___ Workplace
___ ___ 16.) Boils, skin infections
___ ___ 17.) Bruise easily
___ ___ 18.) Allergic reaction to insect bites
___ ___ 19.) Changes in color of skin
___ ___ 20.) Changes in nails or hair

Now Past EYES:
___ ___ 21.) Frequent Headaches
___ ___ 22.) Eyesight getting worse
___ ___ 23.) Wear glasses
___ ___ 24.) Weart contact lens
___ ___ 25.) See double
___ ___ 26.) See colored halos around lights
___ ___ 27.) Temporary loss of sight
___ ___ 28.) Glaucoma
___ ___ 29.) Pain in eyes
___ ___ 30.) Difficulty in seeing
___ ___ 31.) Trouble in distinguishing color
___ ___ 32.) Blindness (indicate which eye)
___ ___ Excessive tearing

EARS:
___ ___ 34.) Others complain you don't hear them
___ ___ 35.) Feel you have difficulty hearing
___ ___ 36.) Decreased hearing after accident or loud noise
___ ___ 37.) Earaches or ear infections
___ ___ 38.) Ears draining
___ ___ 39.) Buzzing or ringing in ears
___ ___ 40.) Motion sickness in car, plane or boat
___ ___ 41.) Dizziness, lightheadedness or fainting
___ ___ 42.) Loss of balance
___ ___ 43.) Have hearing aid
___ ___ 44.) Dear (indicate which ear) __________

Examining Physician's Initials____________ Applicant's Initials____________

Now Past NOSE, MOUTH, THROAT:

___ ___ 45.) Sores or swelling of gums or jaws
___ ___ 46.) Trouble with tasting
___ ___ 47.) Nose runs when you don't have a cold
___ ___ 48.) Throat sore when you don't have a cold
___ ___ 49.) Hoarseness
___ ___ 50.) Frequent flowing nosebleeds
___ ___ 51.) Swallowing difficult or painful

CHEST:

___ ___ 52.) Tightness, crushing, squeezing in chest after eating
53.) Date last chest x-ray________
Results:_____________________
___ ___ 54.) Wheeze or gasp to breathe
___ ___ 55.) Shortness of breath
___ ___ 56.) Coughing spells
___ ___ 57.) Cough phlegm (thick spit)
___ ___ 58.) Cough up blood
___ ___ 59.) Frequent chest colds
___ ___ 60.) Sweating more frequently or night sweats

HEART:

___ ___ 61.) Told you have hypertension
___ ___ 62.) Told you have high blood pressure
___ ___ 63.) Thumping, racing heart or irregular heartb
___ ___ 64.) Told you have heart trouble
___ ___ 65.) Pain or tightness in chest
___ ___ 66.) Using more pillow to help breathe when ly

STOMACH/BOWEL:

___ ___ 67.) Heartburn or indigestion
___ ___ 68.) Nervous stomach
___ ___ 69.) Belching, bloated after eating
___ ___ 70.) Discomfort in pit of stomach
___ ___ 71.) Feel like vomiting
___ ___ 72.) Vomit blood or coffee ground-like material
___ ___ 73.) Foods that don't agree with you
___ ___ 74.) Diarrhea or constipation (indicate which)
___ ___ 75.) Blood in stool
___ ___ 76.) Black, tarry or very light color stools
___ ___ 77.) Bleeding from rectum
___ ___ 78.) Change in bowel habits

URINARY SYSTEM:

___ ___ 79.) Loss of bladder control when you cough or sneeze
___ ___ 80.) Burning or pain when you urinate
___ ___ 81.) Brown, black or bloody urine
___ ___ 82.) Difficulty starting urine flow or dribbling after urination
___ ___ 83.) Very frequent urination or feeling of need to urinate
___ ___ 84.) Bladder infections

MEN ONLY:

___ ___ 85.) Urine stream weak and slow
___ ___ 86.) Prostate trouble
___ ___ 87.) Burning or discharge from penis
___ ___ 88.) Sore on penis
___ ___ 89.) Genital warts
___ ___ 90.) Lumps or swelling on testicles
___ ___ 91.) Undescended testicle
___ ___ 92.) Impotence

Now Past WOMEN ONLY:

___ ___ 93.) Trouble with mestrual periods
___ ___ 94.) Use of birth control pills
___ ___ 95.) Lumps in breast or armpits
___ ___ 96.) Bleeding, pain, discharge from nipple (indicate which)___________________________
___ ___ 97.) Genital warts
98.) Date of last PAP smear ________________
99.) Date of last menstrual period___________
100.) Number of pregnancies ______________
101.) ____ Full Term
____ Miscarriage
____ Other
___ ___ 102.) Date of last mammorgram____________

NERVOUSE SYSTEM:

___ ___ 103.) Slurred speech or loss of speech
___ ___ 104.) Weakness on one side of body
___ ___ 105.) Tendency to shake or tremble
___ ___ 106.) Dizziness or fainting
___ ___ 107.) Numbness or tingling in any body part
___ ___ 108.) Difficulty in walking

EXTREMITIES:

___ ___ 109.) Stiff, swollen, painful muscles or joints
___ ___ 110.) Trouble stopping cuts from bleeding
___ ___ 111.) Varicose veins
___ ___ 112.) Vein or artery disease
___ ___ 113.) Pains in back
___ ___ 114.) Pains in shoulder or neck
___ ___ 115.) Lumps, swelling in neck or glands
___ ___ 116.) Any back problem
___ ___ 117.) Ever worn a back brace
___ ___ 118.) Ever worn a knee brace
___ ___ 119.) Inflamed veins or blood clots in arms or legs
___ ___ 120.) Numbness or tingling in cold weather
___ ___ 121.) Cramps in legs
___ ___ 122.) Swollen feet or ankles
___ ___ 123.) Painful feet
___ ___ 124.) Burning of soles of feet

TOBACCO

___ ___ 125.) Use tobacco in any form
___ ___ 126.) If yes, specify form
___ Cigarettes
___ Cigars
___ Pipes
___ Chew tobacco
___ Dip snuff
127.) Amount daily _________________________
128.) How many years______________________
129.) If no longer use tobacco, month and year you stopped ____________________

DRUGS:

___ ___ 130.) Illegal use of controlled drugs
___ ___ 131.) Treated for drug problem
If yes, when and where____________________

ALCOHOLIC BEVERAGES

___ ___ 132.) Use of alcholic beverage of any kind
133.) Frequency _________________________
134.) How much - 1 drink = 1 jigger, 1 beer or 1 glass of wine: (Mark X in appropriate box)
Less than 1 ☐ 1-2 ☐ 2-4 ☐ 5-6 ☐ More than 6 ☐
___ ___ 135.) Been told you have a drinking problem
___ ___ 136.) Do you have a drinking problem
___ ___ 137.) Ever treated for alcohol problem
If yes, when and where____________________

Examining Physician’s Initials____________ Applicant’s Initials____________

MEDICINES - Mark an X in the space to indicate medicines you have ever taken or are now taking

Now	Past		Now	Past		Now	Past	
___	___	Antacids	___	___	Dilantin/anticonvulsants	___	___	Nose drops
___	___	Antibiotics	___	___	Diuretics/water pills	___	___	Sedatives
___	___	Birth control pills	___	___	Heart medicine	___	___	Stimulants
___	___	Blood thinners	___	___	Blood pressure medicine	___	___	Tranquilizers
___	___	Codeine	___	___	Insulin	___	___	________
___	___	*Cortisone-type drugs	___	___	Laxatives	___	___	________
___	___	Diet pills	___	___	Muscle relaxants	___	___	________

* Specify reason for use of cortisone-type drug (infection, injury, arthritis)

____

____

____

List dosage & frequency of medicines you are currently taking ____________________

____

____

____

List all medicines you are allergic to ____________________

____

____

PART B - PHYSICAL EXAMINATION

Applicant's Name____________________

PHYSICAL EXAMINATION - To be completed by physician performing examination. Indicate every item which is not within normal limits by placing an X in space provided

1.) GENERAL:
Posture________
Gait ________
2.) SKIN:
Color________
Texture________
Sweaty________
Scars________
Eruptions________
Ulcers________
Petechiae________
3.) HEAD:
Shape________
Hair________
Mases________
Tenderness________
Bruit________
Sinus________
4.) EARS:
External________
Pinna________
Canal________
Drum________
5.) EYES:
Muscles________
Lids________
Sclera________
Conjunctivae________
Cornea________
Pupils________
Fundi________
Macula________
Disk________
Arteries________
Veins________
Exudate________
6.) MOUTH:
Lips________
Breath________
Mucosa________
Dentures________
Teeth________
Tongue________
Gingiva________
Floor________

Palate________
Pharynx________
Tonsils________
Larynx________
7.) NOSE:
Septum________
Obstruction________
Mucosa________
Sinus________
8.) NECK:
Thyroid________
Trachea________
Veins________
Masses________
Bruit________
Carotid________
Spine________
Range of Motion________
9.) LUNGS:
Expansion________
Breath Sounds________
Rales________
Wheezes________
Rubs________
Rhonchi________
Respiratory rate________
10.) HEART:
Rate________
Rhythm________
Thrill________
Rubs________
Murmurs________
Gallops________
11.) BREASTS:
Nodes________
Discharge________
Nipple________
Areola________
Symmetry________
Consistency________
Scars________
Masses________
12.) ABDOMEN:
Contour________
Tenderness________

Masses________
Hernia________
Liver size________cm
Liver edge________
Smooth________
Irregular________
Nodular________
Spleen size________
CVA tenderness________
Rebound________
13.)FEMALE GENITO - URINARY:
Labia________
Clitoris________
Bartholin's gland________
Urethra________
Perineum________
Introitus________
Vagina________
Cervix________
Uterus________
Adnexa________
Culd-de-sac________
Discharge________
14.)MALE GENITO - URINARY:
Penis________
Meatus________
Epididymis________
Varicoceie________
Testicles________
Discharge________
Hernia________
Prostate________
Scars________
15.) RECTAL:
Anus________
Sphincter________
Hermorrhoids________
Mucosa________
Masses________
Pilonidal________
Fissure________
16.) NEUROLOGICAL:
Grasp________

Planar________
Biceps________
Triceps________
Knee________
Ankle________
Romberg________
Babinski________
Coordination________
Tremor________
Vibratory________
Cranial Nerves________
Sensory________
17.) MUSCULOSKELETAL
Shoulder________
Arm________
Elbow________
Radial Pulse________
Wrist________
Hand________
Fingers________
Fingernails________
Spine________
Kyphosis________
Lordosis________
Scoliosis________
Hip________
Leg________
Knee________
Ankle________
Foot________
Pedal pulse________
Toes________
Toenails________
Joints________
18.) EXTREMITIES
Clubbing________
Cyanosis________
Edema________
Veins________
Stasis________
Ulceration________
Hair Distribution________
19.) EMOTIONAL
Speech________
Affect ________
Orientation________
Memory________

Examining Physician’s Initials____________ Applicant’s Initials____________

Height ______________________ Weight ______________________ Temperature__________________

Blood Pressure _______________ If 140/90 or above, recheck in 5 minutes _______________________

Pulse before exercise __________ After jogging in place 1 minute ___________ After 2 minutes rest____

Vision uncorrected ______________________ Corrected ___________________

Hearing (20 feet)______________

Audiogram **(Attach Report)**_______________ Tympanometry **(Attach Report)**____________________

LABORATORY INFORMATION - **Attach Reports**

Comprehensive Metabolic

Routine Urinalysis

CBC

Urine drug screen - To include barbituates, benzodiazepines, cocaine, marijuana, opiates, phencyclidine

INDICATE RESULTS

RPR__________________________________

TB Skin Test or TSPOT__________________

HIV___________________________________

Hemacult______________________________

Remarks on Laboratory Results____

List every item which needs explanation, including items from family history, applicant's history, physical exam and laboratory results.

PROBLEM

PLAN

From your examination of ____, do you consider applicant to have any pre-existing conditions that would disqualify the applicant from a disability retirement with the retirement system? ___________________

If yes, please list pre-existing conditions____

The examination and resulting information truly depicts the condition of the applicant on the ___________ day of _____________________, __________.

Examining physician's name (Type or Print)

Examining physician's signature

Address

Telephone No.

FIREFIGHTERS' RETIREMENT SYSTEM

WAIVER OF PRE-EXISTING CONDITIONS

I, ______________________________the undersigned employee, employed by ____________________________, do hereby apply for membership in the Firefighters' Retirement System. In the event my application is accepted, I hereby waive and renounce any right that I now have or may have to claim disability benefits from the Firefighters' Retirement System for any pre-existing condition, whether the condition is discovered through the enrollment process or otherwise. I acknowledge that R.S. 11:2258(A)(2)(b) provides that the fact that I was determined by medical examination to be fit for employment shall not be considered as indicating the absence of any preexisting injury or medical condition.

I understand that this is waiver in no way affects my eligibility for benefits for conditions not pre-existing at the time of my enrollment.

I am aware that under the provisions of Louisiana R.S. 11:2266, that should I not provide a full and accurate disclosure of all information requested, or should I intentionally make any false statements with respect to my application and the enrollment process, I shall be guilty of a misdemeanor, and subject to prosecution under Louisiana R.S. 11:2266.

THUS DONE AND SIGNED at __________________________, Louisiana in the presence of the undersigned witnesses this ___________day of ___________________, 20________.

Witnesses:

____________________ ____________________

Applicant's Signature

____

COMPLETION OF THIS WAIVER IS NECESSARY FOR YOUR ACCEPTANCE INTO THE FIREFIGHTERS' RETIREMENT SYSTEM