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