# 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.

________ Severe limitation of functional capacity; permanently incapable of any kind of work; totally and permanently disabled from gainful employment.

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

______________________ Date

______________________________ Physician's Name (Please Print)