

**Florida Retirement System
Physician's Report of Reexamination**

PO Box 9000
Tallahassee FL 32315-9000
(850) 488-2968
Toll Free: 1-877-738-3725

Patient Name: _____

SSN: _____

Authorization for Release of Medical Information

I am making application for continuation of disability retirement to the Florida Retirement System. 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.

Patient Signature

Date

Section A

License Number _____
Issued by State Board of Medical Examiners

Physician Name

Mailing Address

Speciality _____

Fax _____

Phone

Section B

1. **Diagnosis:**

a. Most recent examination date: _____

b. Diagnosed condition(s): _____

c. Subjective findings: _____

d. Objective findings: _____

e. Additional comments: _____

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Patient Name: _____ Patient SSN: _____

2. **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
- _____ Severe limitation of functional capacity; incapable of any kind of work

What restrictions have you placed on the patient's activities? _____

3. **Employability Status:**

- a. Is the patient **totally** and **permanently** disabled from gainful employment? Yes _____ No _____
- b. Is the patient capable of performing sedentary employment? Yes _____ No _____
- c. Is the patient capable of employment other than his/her last job? Yes _____ No _____

Additional Comments: _____

Physician Signature

Date