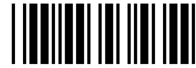
FR-13b
Rev. 06/06
Disability Determination

Florida Retirement System
Physician's Report

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



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 _________________________________

Fax _________________________________

Phone _________________________________

Address _________________________________
____
____

Rule 60S-4.007, F.A.C.

Florida Retirement System
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)