SB-13b
Rev. 03/01
Disability Determination
For Joint Annuitant

Florida Retirement System Pension Plan
Physician's Report

PO BOX 9000 Tallahassee, FL 32315-9000
Local Phone: 850-907-6500 Toll Free: 844-377-1888 FAX: 850-410-2010

Member Name ______________________ Member SSN ______________________

Applicant Name ______________________ Applicant SSN ______________________

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 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.

License Number ______________________
Issued By Florida Board of Medical Examiners

____
Physician's Name (Please print)

Specialty ______________________ Address ______________________

Fax ______________________ ______________________

Phone ______________________ ______________________

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? ______________________

   ____

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2. **Prognosis:**

a) Has the patient's condition stabilized? Yes ________ No ________

b) Has the patient reached maximum medical improvement? Yes ________ No ________

c) 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.

________ Physically or mentally disabled and incapable of self-support.

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

Additional Comments: ______________________

______________________ Physician's Signature

______________________ Date