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
(850) 488-2968
Toll Free: 1-877-738-3725

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 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 Name (Please print)

Specialty _____ Address _____

Fax _____ _____

Phone _____ _____

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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 applicant's condition stabilized? Yes _____ No _____

b) Has the applicant reached maximum medical improvement? Yes _____ No _____

c) Additional comments: _____

3. **Physical and/or Mental Impairment:**

_____ No limitation of functional capacity; capable of 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 Signature Date