DISABILITY PENSION APPLICATION PACKAGE

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NOTE: **EACH PAGE must be consecutively numbered at the top right-hand corner.

CITY OF ORLANDO
400 SOUTH ORANGE AVENUE
P.O. BOX 4990
ORLANDO, FL 32802-4990
(407) 246-3410

ORLANDO FIREFIGHTERS' PENSION BOARD
APPLICATION FOR DISABILITY PENSION
(Please type or print all information, except signature)

Date _____

Name_____

Other names by which you have ever been known: _____

Employee # _____ Rank_____

Social Security # _____ Date of Birth _____

Date of Hire _____ Current Assignment _____

Status of Employment _____

Home Address _____

_____

Home Telephone_____ Work Telephone_____

Email Address _____

◆◆◆

ALL QUESTIONS MUST BE COMPLETED BEFORE THE PENSION BOARD WILL CONSIDER YOUR APPLICATION. IF FURTHER SPACE IS REQUIRED FOR ANY QUESTION, ATTACH ADDITIONAL PAGES, INDICATING THE QUESTION NUMBER TO WHICH THE INFORMATION APPLIES.

IN ADDITION, THE SUPPORTING DOCUMENTATION FOR YOUR APPLICATION ("Application Package") MUST BE PROVIDED WITHIN THIRTY (30) CALENDAR DAYS FROM THE DATE OF FILING YOUR APPLICATION AND IN THE MANNER SET FORTH IN THE BOARD'S "GUIDELINES AND INFORMATION SHEET FOR APPLICATION FOR DISABILITY PENSION."

1. Type of disability pension applied for:

_____line-of-duty _____non-line-of-duty

2. Medical condition for which disability pension sought (be specific):

_____
_____
_____

3. Provide specific information as indicated:

A. Date and time of accident / injury or onset of condition:

_____
_____
_____
_____

B. Where accident / injury occurred or how condition was first detected (be specific):

_____
_____
_____
_____
_____

C. How did accident / injury occur or how was condition first detected (be specific):

_____
_____
_____
_____
_____

D. Provide names and addresses of all witnesses:

_____
_____
_____
_____
_____

E. Was accident / injury reported to supervisor? If so, provide name and date reported.

_____

_____

F. List the name, business address and telephone number of each medical provider (including but not limited to, physicians, surgeons, hospitals, chiropractors, physical therapists, osteopaths) who has treated or examined you, and each medical facility where you have received any treatment or examination for the illness or injury for which you are applying for a disability retirement, or any condition that may be related to it and the dates of treatment. _____

_____

_____

_____

_____

G. What medications are currently being taken? Be specific.

_____

_____

_____

_____

H. Was surgery recommended? If so, by whom and when?

_____

_____

I. Was surgery performed? If so, by whom, when and with what results?

_____

_____

_____

J. Has any further treatment(s) been discussed with you? If so, what is that further treatment(s) and identify by name and address with whom you discussed further treatment(s).

_____

_____

K. State the date on which you reached maximum medical improvement (MMI), and identify by name and address all doctors who have advised you that you have reached maximum medical improvement (MMI).

_____
_____

L. Identify by name and address, all doctors who have advises you that you have not reached maximum medical improvement (MMI).

_____
_____

M. What limitations, if any, have been placed on physical activity (by whom and what limitations)?

_____
_____

N. Have you ever had a similar accident / injury or medical condition in the past to the same part of the body for which this application is filed? If so, state date, place, and circumstances of that previous injury.

_____
_____

O. Did you ever have this same or a related medical condition prior to your employment with the Department? If so, state date(s) and circumstances.

_____
_____

P. If this application is based on a psychiatric or psychological condition, have you ever been diagnosed as having this same condition or any other psychiatric / psychological condition prior to or during your employment with the Department? If so, state what condition, diagnosed / treated by whom, when and where?

_____
_____

Q. Summarize why you believe you are disabled and how your illness or injury prevents you from performing your usual job duties.

_____

_____

4. Were you suffering any injury, disease or disability at the time of the accident(s), incident(s) or conditions(s) for which you are now applying for disability retirement? If so, what was the nature of the injury, disease or disability?

_____

_____

5. Have you ever applied for or received Workers' Compensation, Veterans Administration (VA) benefits, or any other form of compensation or benefits (including, but not limited to, insurance proceeds or settlement, damages as a result of a lawsuit, etc.) due to / as a result of / on account of any accident, injury or medical condition? If so, state what accident, injury or medical condition, when it occurred, when benefits were applied for or received and what compensation or benefits were applied for or received, and what compensation or benefits were applied for or received?

_____

_____

_____

6. Have you ever been involved in an automobile or vehicular accident(s) for which you sought medical treatment or were injured? If so, please provide as to each:

A. When the accident occurred _____

B. Where the accident occurred _____

C. How the accident occurred _____

D. If you were injured, how? _____

E. Was the accident job-related? _____

F. Names, addresses and telephone numbers of all health care providers who treated you.

_____

G. Dates of treatment and course of treatment (specify by whom).

_____

H. Provide the names, addresses and telephone numbers of all persons who may have knowledge of the injuries resulting from the accident.

_____

_____

7. Have you ever had a fall, collision, sports injury, accident, etc. for which you sought medical treatment or were injured? If so, please provide as to each:

A. When the incident occurred _____

B. Where the incident occurred _____

C. How the incident occurred _____

D. If you were injured, how? _____

E. Names, addresses and telephone numbers of all health care providers who treated you.

_____

F. Dates of treatment and course of treatment (specify by whom).

_____

G. Provide the names, addresses and telephone numbers of all persons who may have knowledge of the injuries resulting from the accident.

_____

_____

8. Provide the name(s), address(es) and telephone number(s) of your family physician and / or primary care provider for the last ten (10) years.

_____

_____

9. Other than those listed in numbers 3F or 8, list the names, business addresses and telephone numbers of all other physicians, medical facilities or other health care providers by whom or at which you have been examined or treated in the past ten (10) years; and state, as to each, the dates of examination or treatment and the condition or injury for which you were examined or treated.

_____

_____

_____

10. Has your sworn statement or deposition ever been taken in connection with any claim arising out of the illness or injury for which you seek disability retirement? If so, state the date taken and by whom.

_____

11. Provide the names, addresses and dates of all of your prior and current employers, including information as to a.) The nature of the work involved with each employment, b.) The status (i.e., terminated, continuing, etc.) of each employment and c.) The basis or reason for such status.

_____
_____
_____
_____

12. State whether you are now or ever have been self-employed and, if so, state the name under which you did business, the dates and nature of the work.

_____
_____
_____
_____

13. Please list any extracurricular activities and / or hobbies in which you have participated (ex. sports, bowling, hunting, motorcycle riding, weight lifting / training, running, golf, martial arts, skiing, etc.)

_____
_____
_____

14. Please provide any other information known to you or your attorney that might be relevant to your application for disability retirement.

_____
_____

15. State any other information you want the Pension Board's medical doctor or the Pension Board to consider in making a decision on your application.

_____
_____
_____

YOU ARE REQUIRED TO SUPPLEMENT THIS QUESTIONNAIRE IMMEDIATELY IN WRITING TO THE PENSION COORDINATOR WITH ANY NEW OR ADDITIONAL INFORMATION OBTAINED BETWEEN THE TIME OF SIGNING THIS QUESTIONNAIRE AND FINAL DECISION BY THE BOARD OF TRUSTEES.

I HEREBY SWEAR OR AFFIRM that the information contained in this application, the supporting application package and any additional information provided to the Board of Trustees is true and correct to the best of my knowledge and I understand that a false statement knowingly made on my application can serve as grounds for denial of my application and, further, that I may be subject to criminal and other penalties for false, fraudulent and / or misleading oral or written statements or withholding or concealing information to obtain any benefit available under the pension plan.

I further understand that the Pension Board and its records are subject to the Florida Public Records Act and the Government in the Sunshine Law and that a hearing on my disability application will, by law, be a public hearing and by submitting my application, I hereby authorize the Pension Board to conduct a public discussion of my medical condition and records and, further, release the Board of Trustees, their agents, servants and employees from any liability connected therewith.

_____ _____

Date Signature

SWORN TO AND SUBSCRIBED before me this _____day of _____, 20____.

_____

Notary Public

Personally Known_____or Type of Identification Provided_____

My Commission Expires: