Ft. Pierce Police Officers' Retirement Trust Fund
INTERROGATORIES FOR DISABILITY PENSION BENEFITS

PLEASE PRINT OR TYPE

Name of Employee: _____
(Last) (First) (MI)

Date of Birth: _____ (Attach proof)
Month-Day-Year

Home Telephone Number: _____
(Area Code) Number

Home Address: _____
Number Street

_____
City/Town State Zip Code

PLEASE ANSER ALL QUESTIONS UNDER OATH:

1. Please describe exactly how you were injured/contracted illness, providing specifics as to date, time and place:

   a. Provide names and addresses of all witnesses.

   b. Nature of your injury/illness.

2. Was injury/illness reported to Ft. Pierce Police Department and if so, state date reported and to whom:

3. Please state whether you are claiming the injury/illness to be:

   a. Total and Permanent [ ] Yes [ ] No

   b. Service Related [ ] Yes [ ] No

   c. Non-Service Related [ ] Yes [ ] No

4. Please specifically describe any and all previous conditions that you have had, even though they may not be directly associated with the condition on which your claim is based. For each condition, provide the following (attach a separate sheet if necessary):

   a. Specifically when you had the condition.

   b. Names, addresses and phone numbers of all health care providers with whom you have consulted or who treated you.

   c. The diagnosis.

   d. The prognosis.

   e. Dates of treatment.

   f. Nature of treatment.

   g. Medications prescribed

   h. Names, addresses and telephone numbers of all persons who may have knowledge of such condition.

5. Please provide the names, addresses and telephone numbers of all health care providers who have treated you for the condition upon which your claim is based and any condition related to it. Please provide the following:

a. A brief description of what you were treated for

b. The diagnosis

c. The prognosis

d. Dates of treatment

e. Nature of treatment.

f. Medications prescribed.

g. Names, addresses and telephone numbers of all persons who may have knowledge of such condition.

6. Have you been involved in an automobile or other vehicular accident requiring medical treatment? If so, please provide:

a. When accident occurred:

b. Where and when accident occurred:

c. How accident occurred:

d. Whether you were injured:

e. How you were injured:

f. Was accident job related:

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

(1) Diagnosis

(2) Prognosis

(3) Medications prescribed.

(4) Nature of treatment.

(5) Dates of treatment.

(2) Names, addresses and telephone numbers of all persons who may have knowledge of injuries resulting from the accident.

7. Have you ever had a fall, collision, sports injury/illness or other accident which required treatment by a health care provider? If so, please provide:

a. A description of the incident:

b. Where and when it occurred:

c. How it occurred:

d. Whether you were injured:

e. How you were injured:

f. Was it job related:

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

(1) Diagnosis

(2) Prognosis

(3) Medications prescribed.

(4) Nature of treatment.

(5) Dates of treatment.

(6) Names, addresses and telephone numbers of all persons who may have knowledge of injuries resulting from the accident.

8. Please provide names, addresses and dates of all prior and current employers, including self-employment.

a. Nature of work involved with employment.

b. Status of each employment (terminated, retired, continuing, etc)

c. Basis or reason for any termination of employment.

9. Were you suffering any injury/illness, disease, or disability at the time of the accident, incident or condition for which you are applying for disability retirement?

10. Describe all records of the accident or incident forming the basis of your application, including, traffic accident reports, police reports, notice of injury/illness, hospital records etc.

11. Provide the name and address of all health care providers who have advised you that you are permanently and totally incapable of performing useful and efficient service as a Police Officer as a result of the condition or injury/illness which is the basis of your claim for disability retirement.

12. Provide the name and address of all health care providers who have advised you that you are **not** permanently and totally incapable of performing useful and efficient service as a Police Officer as a result of the condition or injury/illness which is the basis of your claim for disability retirement.

13. State the date on which you reached maximum medical improvement (MMI) for workers' compensation purposes and provide the names and addresses of all health care providers who have advised that you have reached MMI.

14. Provide the names and addresses of all health care providers who have advised that you have **not** reached MMI.

15. Has you sworn statement or testimony been taken in connection with any claim arising out of the injury/illness or condition which is the basis for your claim for disability. If so, state the date taken and by whom.

16. Is there any other information known to you or your agents, which might be relevant to your application for disability retirement? If so, please specify.

17. Have you ever applied for workers' compensation benefits in any jurisdiction? If so, please state for each application:

a. The name and address of the employer.

b. The date of the application.

c. Determination of the application.

d. The dates of receipt of benefits.

18. Describe in detail why you feel that you are permanently and totally unable physically or mentally from performing useful and efficient service as a Police Officer.

Acknowledgments

I hereby certify that the above statements are true and correct to the best of my knowledge. I understand that a false statement may disqualify me for benefits.

I hereby waive my right of confidentiality of my medical records and other medical evidence in order that my application for disability benefits may be properly processed. I understand that in so doing, such records will be discussed during one or more public meetings and will become public record. I understand that the Board(s) will rely upon this waiver and that I will not be able to withdraw same at a later date.

I hereby agree to indemnify and hold harmless the Pension Plan from and against any and all claims, demands, or causes of action of any kind or nature resulting from or in connection with the Board's use of my medical records to process my application, and from and against any resulting losses, costs, expenses, reasonable attorneys' fees, liabilities, damages, orders, judgments, or decrees in connection therewith.

I understand that I have a continuing duty to immediately supplement this questionnaire in writing with any new or additional information obtained.

Dated this _____ day of _____, 20___,

_____ _____
Witness Signature of Participant

_____ _____
Witness Printed name of Participant

STATE OF FLORIDA
COUNTY OF _____

SWORN TO (or AFFIRMED) AND SUBSCRIBED before me this ____ day of

_____, 20___, by _____ *(Participant)* who is:
[ ] Personally known to me ***- OR -*** who [ ] produced the following identification:

_____
Specify type of identification produced

_____ _____
Signature of Notary ***Print, type or stamp name of Notary in addition to seal***