CITY OF LAKE WORTH

FIREFIGHTERS' PENSION TRUST FUND

DISABILITY RETIREMENT APPLICATION CHECKLIST

This is to certify that I have received the following documents for the purpose of applying for a disability retirement:

1. Release for medical information
2. Florida Statute 286.0105
3. Request for reasonable accommodation under the Americans with Disabilities Act
4. Application for Disability
5. Statement of disability by the employer
6. Physician report forms

I understand that the above listed forms and documents must be completed in their entirety and returned to the retirement office before my application can be processed.

_____

Applicant - Print Name

_____

Applicant's Signature

CITY OF LAKE WORTH
FIREFIGHTERS' PENSION TRUST FUND

RELEASE OF MEDICAL INFORMATION

The undersigned applicant for disability retirement from the City of Lake Worth Firefighters' Pension Trust Fund hereby authorizes the Board of Trustees, its agents, servants, and employees to receive any and all reports, x-rays, charts, documents of every kind and description, including psychiatric reports, evaluations, and information relating to my medical condition. This form shall also serve as authorization for any treating physician, hospital, former employer, health care provider, or any other person to furnish to the Board of Trustees originals or complete copies of all records, reports, findings, charts, documents, x-rays, of every kind and description, concerning my treatment and care.

I further understand and authorize the Board of Trustees or any person acting on their behalf to include any discussion of this medical information in its official records and understand that should my medical condition ever become an issue regarding approval or denial of disability retirement, that said information may become the subject of a public discussion at a meeting governed by the Government in the Sunshine Law and/or a public record governed by the Florida Public Records Act.

I agree as a condition of application for disability retirement to the utilization of that information as described and release the Pension Plan, the Board of Trustees, their agents, servants and employees from any liability connected with the utilization of those medical records as described in this form.

A photocopy of an executed form shall have the same force and effect as an original.

_____
Applicant - Print Name

_____
Applicant's Signature

Dated:_____

CITY OF LAKE WORTH
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REASONABLE ACCOMMODATION FORM

TO: HUMAN RESOURCES DEPARTMENT

FROM: _____

I hereby request a reasonable accommodation as follows:

1. Current job title: _____

_____

2. Department or Division: _____

_____

3. Immediate supervisor: _____

4. Describe your disability: _____

_____

_____

_____

_____

_____

_____

_____

5. Describe your current job duties: _____

_____

_____

_____

6. Describe job duties or tasks you are unable to perform due to your disability: _____

_____

_____

_____

_____

7. Describe the accommodation you believe would help you perform your job duties: _____

_____

_____

_____

_____

_____

_____
Name - Print

_____
Signature

Date_____

CITY OF LAKE WORTH
FIREFIGHTERS' PENSION TRUST FUND

STATEMENT OF DISABILITY BY EMPLOYER

Employee's Name: _____

Social Security No.:_____

Department:_____

Date of hire:_____

Employee has or will terminate upon: _____

Our office has been notified that this employee is applying for a disability retirement for the following reason:

_____

_____

_____

_____

_____

Present job title and assignment:_____

_____

Was the employee prior to his/her alleged disability, able to perform all of the duties of the position fully and completely? If not, list those duties which could not be performed.

_____

_____

_____

_____

_____

Does the employee's alleged disability prevent the performance of any of his or her current duties? If so, how does the disability affect his or her performance? _____

_____

_____

_____

_____

_____

How many days has the employee been absent from work this year?

_____

What percentage of this absence is directly related to the present alleged disability?
_____

What other jobs exist that this employee could perform despite his/her alleged disability? _____

_____

_____

If there are other jobs which the employee can perform, has one been offered? _____

If another job has been offered, why was it not accepted?

_____

_____

_____

_____

If you regularly evaluate your employees, attach a copy of the last performance evaluation prior to the date of the alleged injury or illness resulting in disability.

What other comments would you make concerning this employee's condition as it relates to his/her continued or restructured employment? _____

_____

_____

_____

_____
Print Name

_____
Signature

_____
Official Position

_____
Date

CITY OF LAKE WORTH
FIREFIGHTERS PENSION TRUST FUND

APPLICATION FOR DISABILITY RETIREMENT

Date:_____

Name:_____

Social Security
No.:_____

Department Name:_____

Job Title:_____

Date of Employment:_____

Date of Entry into Pension Plan:_____

All questions must be completed before the Trustees of the Pension Plan will consider your application. If further space is required on any question, attach additional pages, indicating the item to which the information applies:

1. Have you asked your employer to make a reasonable accommodation for your within your limitations, as defined by the Americans With Disabilities Act? (Documentation of this inquiry and the response must be attached)

   YES_____ NO_____

2. Do you currently have any disciplinary action pending against you? If yes, please explain.

   YES_____ NO_____

3. Describe the illness or injury which has caused your disability.

   _____

   _____

   _____

_____

_____

4. List the names and addresses of all physicians, hospitals, rehabilitation facilities, or any other person who has provided medical treatment in connection with your disability.

_____

_____

_____

_____

5. Has any physician restricted your activities?

YES_____ NO_____

If yes, please describe the restrictions._____

_____

_____

_____

_____

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

_____

_____

_____

_____

7. If you have ever been injured for any reason requiring medical treatment prior to this date, list the date of the injury, cause, treatment you received, name the physician attending you, hospital or clinic where treatment was performed, the date of recovery, and any present disability resulting there from._____

_____

_____

_____

_____

8. While you were injured, did you receive any disability benefits from your employer? If the answer is yes, please identify the date benefits commenced and the date benefits terminated.

YES_____ NO_____

9. If you have any other physical impairments, please describe them and the length of time they have existed.

_____

_____

_____

_____

_____

I hereby apply for a disability retirement and I affirm that all the informational statements contained herein are true and correct to the best of my knowledge. I understand that a false statement knowingly made on my application can serve as grounds for denial of my application.

_____ _____
Print Name Social Security No.

_____ _____
Signature Street Address

_____ _____
Telephone City/State/Zip Code

CITY OF LAKE WORTH
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PHYSICIAN REPORT FORM

Name of physician:_____

Address: _____

_____

Telephone:_____

Area of specialization:_____

Board certification, if any:_____

Florida Medical License No.:_____

I examined _____ (name of applicant) in connection with his application for a disability retirement. The results of my examination are attached. (Attach narrative)

Description of medical condition:_____

_____

_____

_____

Cause/origin of condition:_____

_____

_____

_____

On the basis of the attached findings, it is my opinion that the applicant:

1. Is/is not permanently disabled (circle appropriate response) from regular and continuous duty as a fire fighter. If the applicant is not permanently disabled, explain:_____

_____

_____

_____

2. The applicant is/is not totally disabled (circle appropriate response) from regular and continuous duty as a fire fighter.

If the applicant is not totally disabled, explain:_____

_____

_____

_____

3. The illness or injury giving rise to the disability did/ did not occur in the course and scope of the employee's duties with the Lake Worth Fire Department and/or Palm Beach Fire Rescue (circle appropriate response).[1]

If the illness of injury is not service connected explain:_____

_____

_____

_____

_____
Physician - Signature

[1] Disabilities resulting from heart disease, hypertension, and tuberculosis are presumed to be job related under Fla.Stat. §175.231; disabilities resulting from hepatitis, meningococcal meningitis and tuberculosis are presumed to be job related under Fla.Stat. §112.181.