CITY OF MARCO ISLAND FIREFIGHTERS' PENSION FUND
APPLICATION FOR DISABILITY RETIREMENT

To: Board of Trustees
City of Marco Island
Firefighters' Pension Fund

From: Applicant:_____
Address: _____
_____
_____
(Do not use post office box)

Job Title: _____
Employment Date: _____
Home Telephone: _____

DOB: _____ SSN#: _____ Married: Yes __ No __ Date of Marriage: _____

Name of Spouse/Beneficiary: _____ DOB: _____ SSN#: _____
Address of Spouse/Beneficiary: _____

I hereby apply for disability retirement as provided by the City of Marco Island Firefighters' Pension Fund Code. I claim this disability to be: ☐ Service-incurred ☐ Non-Service-incurred

Doctors' diagnosis:_____

Cause of disability:_____
_____

Accident date:_____ Location:_____

How does the claimed disability affect your work?_____
_____

Did you request the City of Marco Island and/or the Fire Department to make a reasonable accommodation (under the Americans with Disabilities Act) to your claimed disability? ☐ Yes ☐ No
If yes, please attach a copy of your written request and the City's response. If no, please attach an explanation of why you did not request such an accommodation.

List below (or attach a separate sheet) the Name, Address (must include street, city, state, zip) and Telephone Number (including area code) of your family/primary physician and **ALL** doctors, facilities or hospitals who have treated you for the above condition.

_____
_____
_____
_____

I hereby consent, on behalf of myself and any other person entitled to receive monies or benefits by virtue of this application and any resultant pension to investigations (or any nature, type, manner or means) of matters which would in any way bear upon the obligation of the Board of Trustees to pay or continue to pay monies or benefits on account of this application and any resultant pension, at any time and from time to time, without further consent by or notice to anyone including myself, whether conducted by the Board of Trustees or on its behalf, and regardless of whether or not such investigations and/or the reports or results thereof are within the scope of the Fair Credit Reporting Act and/or any other federal, state or local law.

_____
Signature of Applicant
Date: _____

_____
Signature of Witness
Date: _____

INCOMPLETE FORMS WILL BE RETURNED TO APPLICANT FOR COMPLETION
(HIPPA Medical Release and Waiver of Confidentiality Forms must accompany this Application)

MARCO ISLAND FIREFIGHTERS' PENSION FUND

Authorization to Use or Disclose Health Information

Name:_____ Date of Birth:_____

I HEREBY AUTHORIZE the disclosure to and the use of the above named individual's health information as described below.

1. The following individual(s) or organization(s) are authorized to make the disclosure:

   Any and all Physicians, Facilities and/or Hospitals who have provided treatment.

2. The type of information to be used or disclosed is my entire medical/health record.

3. I understand that the information in my medical/health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. The information identified above may be used by or disclosed to:

Name of Client	Marco Island Firefighters' Pension Fund c/o Sugarman & Susskind, P.A.
Address of Client	100 Miracle Mile Blvd. Suite 300 Coral Gables, FL. 33134

5. This information for which I'm authorizing disclosure will be used for the following purpose:

To facilitate the Board of Trustees of the **Marco Island Firefighters' Pension Fund** in the carrying out its duty to review, discuss and determine my application for disability retirement. I hereby waive the right of confidentiality of medical/health records and other medical evidence in the custody of the Board of Trustees or elsewhere. I further understand that such records will be discussed during one or more public meetings and will become public record. I understand that the Board of Trustees will rely upon this waiver.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical/health care provider. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my insurance policy.

7. This authorization will expire six months from the date on which it was signed.

8. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

9. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

10. I also authorize the use of photocopy of this document in place of the original.

_____ _____

Signature of patient or legal representative Date

If signed by legal representative, relationship to patient:_____

Signature of witness:_____ _____

Date