CITY OF OKEECHOBEE
MUNICIPAL FIREFIGHTERS' PENSION FUND

AFFIDAVIT OF DISABILITY BENEFIT RECIPIENT
(Not to be used with Application for Disability Retirement)

STATE OF _____

COUNTY OF _____

Before me, the undersigned authority, personally appeared _____, who being duly sworn deposes and says:

1. I am currently receiving disability retirement benefits from the City of Okeechobee Municipal Firefighters' Pension Fund.

2. In the immediately preceding calendar year, I received income from the following sources:

a.	Workers' Compensation.	Yes [ ]	No [ ]
b.	Any employer.	Yes [ ]	No [ ]
c.	Self-employment.	Yes [ ]	No [ ]
d.	Other earned income. If yes, please state the source.	Yes [ ]	No [ ]

3. My current employment involves the following physical activities:

4. The current status of the condition upon which my disability benefits are based and my limitations resulting from such condition are as follows:

5. I engage in the following sports and recreational activities:

6. Attached is my treating physician's report specifically and completely stating:

a. The status of the condition upon which my disability benefits are based.

b. That I remain totally and permanently disabled from rendering useful and efficient service as a firefighter and the reasons therefor.

c. The restrictions and limitations resulting from such condition.

7. Attached is additional information that I deem relevant for the Board's consideration in reviewing my continued benefit entitlement. ____ yes ____ no

8. I authorize the Board to utilize this affidavit and any attachments in any public meetings it may have regarding my disability status. I further waive any statutory or common law right of privacy I may have in these records, if necessary to enable the Board to discuss these records in any public meetings in connection with my disability status.

_____
Signature

Sworn to and subscribed before me this _____ day of _____, 20___.

_____
Notary Public

Personally Known: ___ or Produced Identification: ___

Type of Identification Produced:_____

* **This form is to be completed only by those persons <u>currently</u> receiving disability benefits.**