TO: **APPLICANTS FOR DISABIILTY PENSION**

SUBJECT: **APPLICATION REQUIREMENTS**

Attached you will find the following:

1. Guidelines and Information Sheet for Application for Disability Pension
2. Application for Disability
3. Physician's Report Form
4. Authorization to Release Medical, Psychological and Employment Information
5. Table of Contents
6. Applicant's Certification of Completion

As noted on the Guidelines and Information Sheet (Item 1), it is incumbent on **you**, the applicant, to provide all relevant information which will support your request for a disability pension **and** to provide such information in a format as directed by the Pension Board of Trustees.

In order to assist you in this process, the above-listed documents are being provided. Because these cases require a substantial amount of documentation and because the Board of Trustees requires uniformity in the process to insure a thorough and fair consideration of all applications; you adherence to these requirements is mandatory; this includes use of the forms provided **without** change or alteration. Failure to so utilize these forms will result in your application being considered incomplete and unacceptable for presentation to the Board.

Please read the "Guidelines and Information Sheet for Application for Disability Pension" and other attached documents carefully. You must first complete and file the "Application for Disability Pension." Thereafter, you must assemble your "application package" in accordance with the Table of Contents (Item 5) and complete the Applicant's Certification of Completion (Item 6), which in effect advises the Pension Board that you have completed your application process.

The original of the completed "Application Package" should be placed in a three-ring notebook, in the order following the Table of Contents and including the Applicant's Certification of Completion. Please submit two (2)) completed copies of the "Application Package" on individual thumb drives. The one (1) original notebook, another copy in a 3-ring notebook and the two thumb drives must be filed with the Pension Coordinator, Office of Business and Financial Services, 4th Floor, City Hall within thirty (30) calendar days after the date you filed your application. When the Independent Medical Examination (IME) is scheduled, you will be notified of the date/time in writing. Thereafter, you will be notified of the date/time of the preliminary disability hearing before the Board of Trustees.

Questions: Please contact the Pension Coordinator at 407.246.3410.

GUIDELINES AND INFORMATION SHEET
FOR
APPLICATION FOR POLICE DISABILITY PENSION

1. Application for Disability Pension, whether line of duty or non-line of duty, shall be on the application form provided. ***Each application will be considered and determined by the Pension Board on the application's own merits***.

2. All information must be submitted, and all questions answered fully and accurately on the form provided.

3. The ***burden is on the applicant*** to provide, at the applicant's expense, complete documentation in support of the application, including reports from physician(s) on the form provided, physicians' office notes, reports of hospitalization and/or surgery, test results, and other medical information pertaining to the medical, psychiatric or psychological condition for which the disability pension is sought.

4. Guidelines for the supporting documentation ("application package") are as follows:

   A. The application package should be organized into a 3-ring notebook binder in the order set forth in the Table of Contents (Item 5) in this packet. Each new section should be separated and marked with a tab and EACH PAGE must be consecutively numbered at the top right-hand corner of each page. If the disability is based on multiple injuries/illnesses, Tabs 2-12 shall be completed for each injury/illness, but included in one notebook. If no documents exist for a particular section, please provide a statement to that effect under the appropriate Tab number. Once complete, compile a second notebook in another 3-ring notebook. The application package will also be copied onto two thumb drives.
   B. Tab 1 – Application for Disability Retirement – your completed and signed application.
   C. Tab 2 – Copy of Initial Accident/ Injury Report(s) (in chronological order).
   D. Tab 3 – Hospitalization/Surgical Reports (in chronological order) – provide a copy of all such documents that pertain to your injury/medical condition.
   E. Tab 4 – Physician Notes from every doctor you have seen regarding your disability injury (in chronological order) with the exception of Centra Care doctors. All physician records should be in chronological order, starting with the earliest date of treatment.
   F. Tab 5 – Florida Hospital Centra Care Records – (in chronological order) provide a copy of the ENTIRE medical file of Centra Care including but not limited to ALL medical records, reports, office notes, treatment plans, test results, etc.
   G. Tab 6 – Diagnostic Reports (in chronological order) – provide reports of x-rays, MRIs, CT Scans, nerve conduction studies, EEGs, EKGs, etc.
   H. Tab 7 – Pre-employment physical.
   I. Tab 8 – Any other supporting documentation.
   J. Tab 9 – Authorization to Release Medical Information
   K. Tab 10 – Certification of Completion
   L. Tab 11 – Completed Physician's Report from Primary Physician. **The Physician's Report(s), prepared on the form provided by the City, shall not be dated more than 60 days prior to the date of submission of the application package or the Board will not consider it/them evidence.** The Report and the medical documentation **should not** be sent directly to the Board but should be included in your package.
   M. Tab 12 – Independent Medical Evaluation – provide a section divider and Tab number for the future IME report.

PROCEDURES

1 The application package must be submitted within thirty (30) calendar days of the date the application is filed. Two notebooks in two (2) three-ring binders and two (2)copies of the notebooks should be submitted on thumb drives. It is not the responsibility of the Pension Board to secure the information on behalf of the applicant; the applicant has the affirmative obligation to secure and provide all necessary supporting documentation in a timely fashion.

2. The two (2) completed application package notebooks and two (2) copies of the complete notebook on thumb drives in the format mandated by the Pension Board and on the forms provided by the Pension Board shall be filed with the Pension Coordinator, 4th Floor, Orlando City Hall. Upon receipt, the Pension Coordinator will review the notebook(s) and add the document to the OneDrive. The Pension Board will be notified of the receipt and the Board Attorney will review the notebook for completeness. Once the attorney is satisfied with the contents, the Pension Coordinator will arrange for Centra Care to have a courier pick up the notebook and begin the process of securing a doctor to perform the Independent Medical Examination "IME".

3. Each applicant must submit to an Independent Medical Examination with a medical doctor selected by Centra Care. If an IME cannot be scheduled in a reasonable amount of time, the Board may allow a treating physician to complete the IME.

4. Depositions may be taken, upon proper notice to the parties, in accordance with the format in Rule 1.310 of the Florida Rules of Civil Procedure. Testimony for the hearing may be by deposition and must be submitted in advance in order to give the Board more time for review and consideration.

5. After submission of the application package notebooks, requests for medical records, past or present employment records or workers compensation records, and notices of depositions shall be in writing with a copy to the other party (Applicant or Applicant's Counsel, or Department's Counsel c/o City Attorney's Office, City of Orlando) with a copy to the Pension Coordinator, 4th floor, Orlando City Hall.

6. All evidentiary materials, case histories, additional medical reports, depositions, etc. must be submitted to the Pension Coordinator, with copies to the applicant or applicant's counsel and the Police Department Advocate, no later than **seven calendar days** prior to the scheduled Disability Hearing. If materials are not submitted by that time, a Motion to Continue must be filed and the hearing may be rescheduled upon good cause shown. Any rebuttals or responses to documents would need to be filed within **three business days**.

7. Upon receipt of the report from the Independent Medical Examination an initial hearing will be scheduled by the Board with all parties.

8. The Pension Board will generally schedule a hearing on the application upon agreement of the applicant (or applicant's counsel) and the Police Department's counsel, but such hearing shall be scheduled within sixty (60) calendar days after receipt of the IME report by the applicant (or applicant's counsel) and Police Department's counsel.

9. The Pension Board may require the applicant to submit to further consultations and/or examinations by physicians selected by the Board, with the cost thereof to be borne by the Board. This option, purely at the discretion of the Board, shall not be construed to relieve the applicant from the burden of providing sufficient evidence in support of the application.

10. The applicant is entitled to be represented by legal counsel of applicant's choosing, and at applicant's expense, in the presentation of the application for disability retirement. If the applicant is to be represented by legal counsel, such attorney must file a Notice of Appearance with the Pension Coordinator, 4th Floor, Orlando City Hall with a copy of such notice to the Board Attorney. The Police Department is also entitled to be represented by legal counsel or a departmental advocate. The Board may choose to retain outside counsel to act as the Advocate to represent its interests.

11. The applicant may appear at the hearing(s) in person. The Board may take testimony, under oath, from the applicant, from the Department representatives, and other witnesses and may consider any other relevant evidence. The applicant shall be responsible for ensuring the appearance of witnesses at the hearing. Such witnesses are subject to examination and cross-examination by legal counsel for the applicant and the Department. Members of the Board and the Board's legal counsel shall also be entitled to ask questions of the witnesses.

12. The Board shall determine, based upon competent substantial evidence, whether the applicant has proven by a preponderance of the evidence the member's entitlement to a disability pension. Entitlement shall be based on the provisions governing the pension fund.

13. The hearing is a formal, quasi-judicial proceeding. The strict adherence to the rules of procedure and evidence shall not be required. The Board, by majority vote of members present, may grant the request as presented, deny the request as presented, or grant a type of disability retirement other than as requested, or take any other action in accordance with state and local laws.

14. If the Board denies the applicant a pension, the applicant may seek review by way of certiorari in the Ninth Judicial Circuit Court.

15. If the disability retirement is granted, the Board shall specify the date on which such retirement is effective and direct the Board Attorney to prepare a Final Order reflecting the Board's decisions. If the disability retirement is not granted, the Board Attorney will be directed to prepare a Final Order reflecting the Board's decision. Employee Benefits will be tasked with making the necessary computation of monthly benefits and shall authorize the Office of Business and Financial Services to make disbursements accordingly. The Board at the next regular meeting following its decision granting retirement shall confirm said computation.

Questions concerning the application process may be directed to the Pension Coordinator (407-246-3410).

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_____

Date of Birth:_____ Date of Hire _____

Current Assignment_____

Status of Employment _____

Home
Address_____

_____

Home Telephone _____ Work Telephone _____

Personal 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 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/condition 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 advised you that you have not reached maximum medical impairment (MMI).

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

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 condition(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 other 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. 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.

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 mployment, 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, 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 here 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:

PHYSICIAN'S REPORT

Date _____

MEDICAL/DISABILITY RETIREMENT APPLICATION OF_____

Dear Dr._____

The above referenced individual has applied to the Pension Board for a disability pension. This is a separate and distinct process from a workers' compensation claim. The Board requires specific answers to the following questions in order to render a fair and equitable decision on this application. Your cooperation in **thoroughly** answering these questions is appreciated. To assist you with these questions, a copy of the current job description for a police officer is attached.

If further space is required for any question, please attach additional pages, indicating the question number to which the information applies.

The information requested herein should be furnished **directly to the applicant** (who, in turn, will be assembling an application "package" for presentation to the Board). Please do not send this Physician's Report to the Pension Board.

1. What is the injury/condition for which you saw and/or treated the applicant? Explain fully.

_____

_____

_____

_____

2. Is the current condition permanent or temporary? Explain fully.

_____

_____

_____

_____

3. Is the condition degenerative? Explain fully.

_____

_____

_____

_____

4. Is the condition/disability partial or total? Explain fully.

_____

_____

_____

_____

5. What is the applicant's current medical status?

_____

_____

_____

_____

6. If condition or disability is PTSD or a different psychological or psychiatric health issue, please detail the DSM V criteria as follows:

a. Stressor_____

_____

b. Intrusion symptoms_____

_____

c. Avoidance_____

_____

d. Negative alterations in cognitions and mood_____

_____

e. Alteration in arousal and reactivity_____

_____

f. Duration_____

_____

g.Functional significance_____

_____

h. Exclusions_____

_____

i. Specifications_____

_____

NOTE: With reference to Questions 7 through 13, please review and consider the attached Job Description.

7. Can the condition be controlled and/or cured by the use of medication? (If YES, specify "control" or "cure", the medication, and any known side effects of such medication). Explain fully.

_____

_____

_____

_____

8. If yes, can the condition be so controlled and/or cured to the extent that the applicant can perform his/her duties as a police officer? Explain fully.

_____

_____

_____

_____

9. Can the condition be controlled and/or cured by surgery? (If YES, specify "control" or "cure" and the nature of the surgery.) Explain fully.

_____

_____

_____

_____

10. If yes, can the condition be controlled and/or cured to the extent that the applicant can perform his/her duties

as a police officer? Explain fully.

11. a. Can the condition be controlled and/or cured by means other than medication or surgery (i.e., physical therapy, exercise, weight control, stop smoking, diet, counseling, etc.)? Explain fully.

b. If yes, can the condition be controlled and/or cured to the extent that the applicant can perform his/her duties as a police officer? Explain fully.

12. In light of the present condition, what restrictions (if any) would you impose on the individual's activities, including continued employment as a police officer (see job description)?

13. Does the medical condition render the member (police officer) unfit to perform the required duties of the member's rank?

14. Based on the current condition of the applicant is he or she capable of performing the limited duty assignments listed below? If so to what extent? Please indicate your responses below.

CAN THE APPLICANT:	Yes	No	Comments
Work shift work?			
Work 40 hours a week?			
Complete police reports by (phone, hand-written or computer), interview and take statements from victims and witnesses where no suspect is present.?			
Respond to non-hazardous calls for service including, but not limited to investigating traffic crashes and processing crime scenes?			
Ride in a police vehicle and enter and exit the vehicle unassisted?			
Operate a police radio including use of handheld microphone or radio with foot pedal?			
Perform general office duties to include answering the telephone?			

15. Do you have any personal knowledge OR a professional medical opinion as to whether the disability is directly caused by and attributable to the performance of duty as a member of the Police Department? Explain fully.

_____

_____

_____

_____

16. Is the condition for which you saw and/or treated applicant related to/the result of/caused by any other medical condition, including because of or due to the aggravation of a specific injury, impairment or other medical condition pre-existing the member's employment with the Police Department? Explain fully.

_____

_____

_____

_____

17. Is the medical condition related to/the result of/any of the conditions referred to below?

Excessive and habitual use by the police officer of drugs, intoxicants, or narcotics;

Injury or disease sustained by the police officer while willfully and illegally participating in fights, riots, civil insurrections or while committing a crime;

Injury or disease sustained by the police officer while serving in any armed forces;

Injury or disease sustained by the police officer after employment has terminated;

Injury or disease sustained by the police officer while working for anyone other than the city and arising out of such employment. Explain fully:

_____

_____

_____

_____

_____

_____

18. Is the present condition related to/the result of/caused by any congenital or childhood medical condition? Explain fully:

19. Did the impairment or other medical condition for which the applicant is seeking disability benefits pre-exist the date of employment of the applicant?

Explain fully:

20. What medication or other treatment is presently being prescribed and what is the dosage ***or treatment***? Explain fully:

21. How long has the individual been under your care, for this or any other condition?

22. In what particular "specialty" area(s) of medicine do you practice? Are you Board Certified in those areas?

23. Please provide any additional comments or information that you feel is pertinent to the board's decision. You may attach additional information.

_____
_____
_____
_____

In addition, the Pension Board will need copies of any and all test results, reports of hospitalization and/or surgery, office notes, and any other reports in your chart concerning this individual which should be requested by the applicant to be provided to the Board.

The information requested herein should be furnished **directly to the applicant** (who, in turn, will be assembling an application "package" for presentation to the Board). Please do not send this Physician's Report to the Board.

Thank you for your cooperation.

Orlando Police Pension Board

_____
Physician's Signature

_____
Typed or Printed Name of Physician

_____
Date

Attachment: Police Officer-Job Description

AUTHORIZATION TO RELEASE MEDICAL, PSYCHOLOGICAL AND EMPLOYMENT INFORMATION
(including PROTECTED HEALTH INFORMATION)

I, _____, hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider or other person who has attended, examined, or furnished medical services to me ("My Providers") to disclose my entire medical record and any other protected health information concerning me to:

the City of Orlando, Orlando Police Pension Board, or their authorized representatives (including Florida Hospital and Florida Hospital-Centra Care), and any medical provider to whom I am referred for an Independent Medical Examination.

The protected health information authorized for release is as follows:
any and all information with respect to any illness or injury, medical history, diagnosis, consultation, prescriptions, or treatments and copies of all hospital or medical records pertaining thereto, including but not limited to intake questionnaires, reports, x-rays, diagnostic tests, films, charts, and other documents of every kind and description including psychiatric reports and/or evaluations and drug or alcohol use information.

I further hereby authorize full and complete disclosure of the records of educational institutions, military agencies/units, U.S.Veteran's Administration, current and former employers or any other person to furnish complete copies of all records of every kind or nature, including but not limited to reports, findings, charts, documents, x-rays, diagnostic tests, films and evaluations, concerning my medical history, diagnosis, treatment or care, and my employment.

The protected health information to be disclosed under this authorization is for the purpose of: Consideration of my application for disability pension and for making related fitness for duty decisions.

This authorization will expire twelve (12) months following the date of my signature below. I understand that I have the right to revoke this authorization, in writing. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this authorization to disclose information about me. I further understand that if I refuse to sign this authorization to release my complete medical records or revoke this authorization, my application for disability pension will not be able to be processed.

I understand that a refusal to sign this authorization will not result in a denial of health care by My Providers.
I further understand that once the protected health information is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal HIPAA privacy regulations.

A copy of this executed authorization shall be considered as effective and valid as the original.

I HAVE FULLY READ AND UNDERSTAND THIS AUTHORIZATION FOR RELEASE OF INFORMATION.

_____ _____
NAME OF PATIENT (Print) DATE

_____ _____ _____
PATIENT (Signature) Social Security Number (last 4 digits only) Date of Birth

_____ _____
WITNESS (Print) WITNESS (Signature)

Rev. 10/13/11

DISABILITY PENSION APPPLICATION PACKAGE

TABLE OF CONTENTS

**NOTE: Each page must be consecutively numbered at the top right-hand corner of each page.

APPLICANT'S CERTIFICATION OF COMPLETION

I, _____, hereby
(Print or Type Name)

certify that I have been made aware of the requirements for filing an Application for Disability Pension, have been furnished all required forms, have completed all such forms which I am required to complete, and have secured all medical documentation pertaining to my application.

I hereby certify that all records obtained by me have been included in this application package.

I also hereby certify that I have not made any false, fraudulent or misleading written statements and I have not withheld or concealed material information to obtain any disability benefit available under my retirement plan.

Accordingly, I hereby certify that my application package is complete and that I have furnished the original plus the required number of copies on CD (8) of said application package to the Pension Coordinator, 4th Floor City Hall.

_____
Signature of Applicant

_____
Employee Number

_____
Date