CITY OF BATTLE CREEK
POLICE AND FIRE RETIREMENT SYSTEM

APPLICATION FOR DISABILITY RETIREMENT

Personal Data:

1. Name: _____

2. Address: _____

City/State/Zip: _____

3. Phone: Work: _____ Home: _____

4. Date of Birth: _____ Date of Hire: _____

5. Department: _____

6. Job Title: _____

Detail of Initial Injury/Illness:

7. Date of injury/onset of condition: _____

8. Describe in your own words your injury/illness: _____
(attach additional pages if necessary)

_____

_____

_____

You will need to provide copies of all Personal Injury and Illness Reports, Supervisor's Incident Investigation Reports, and any other forms and/or reports that are required by your department. You will also need to collect all applicable medical records from your physicians. These items must be turned in together with this application.

Additional Injury/Illness Information:

9. Dates and details concerning any recurrence: _____

_____

_____

10. Limitations/restrictions on work you may perform *(attach appropriate medical substantiation)* : _____

_____

_____

11. Medical treatments, surgeries, etc., and name of treating physicians relative to Questions 7, 8, 9 and 10:

_____

_____

_____

12. Attempts by yourself or the City to obtain placement on alternate work sites, rehabilitation, etc.:

_____

_____

Independent Medical Evaluation:

13. Provide below the name address and telephone number of the physician who will be conducting the Independent Medical Evaluation on your behalf. A letter of instruction from this office to this physician must be sent before the examination can be conducted:

Physician Name: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

Please note: the physician you select must be independent and apart from previous medical involvements funded by the City of Battle Creek. The physician must also be qualified in the field of the claimed disability.

Additional Information:

14. Sign the attached Authorization for Release of Records & Designation of Physician in order to process your application.

15. Complete the appropriate statement below:

I hereby state that I am totally and permanently, physically or mentally incapacitated for duty as a

_____ as the result of personal illness or injury. The reason(s) I cannot perform the duties of my job are: _____

_____

_____

16. By signing below, I understand and agree with all of the following statements:

A. I must appear for a physical evaluation before the physician or physicians designated by the Pension Board at such time and place as arranged by the Pension Board.

B. By signing this application, I am waiving all rights to the confidentiality of my medical records concerning my disability.

C. My records will be copied and distributed to Trustees as necessary for them to make a fair and accurate decision regarding my claim.

D. The physician representing me must be independent of prior medical service provided to me on behalf of the City of Battle Creek.

E. The physician representing me must be qualified in the field of the claimed disability.

F. The statements on this Application are true and complete to the best of my knowledge. I understand that providing false information on this Application is a violation of law, for which I may be subject to disciplinary and/or legal action.

Date: _____ Signature: _____

Witness: _____