FR-13f
Rev. 07/06
Disability Determination

Florida Retirement System
Physician's Report of Reexamination

PO BOX 9000 Tallahassee, FL 32315-9000
Local Phone: 850-907-6500 Toll Free: 844-377-1888 FAX: 850-410-2010

Patient Name: _____ SSN: _____

Authorization for Release of Medical Information

I am making application for continuation of disability retirement to the Florida Retirement System. I authorize my physician to release any information recorded on the examination report and any other pertinent facts and documents concerning my condition to the Florida Retirement System.

_____ _____
Patient Signature Date

Section A

License Number _____ _____
Issued by State Board of Medical Examiners Physician Name

_____
Mailing Address

_____

_____

Speciality _____ _____

Fax _____ _____
Phone

Section B

1. **Diagnosis:**
   a. Most recent examination date: _____
   b. Diagnosed condition(s): _____
   c. Subjective findings: _____
   d. Objective findings: _____
   e. Additional comments: _____

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Patient Name: _____ Patient SSN: _____

2. Physical and/or Mental Impairment:

_____ No limitation of functional capacity; may return to work.

_____ Slight limitation of functional capacity; capable of light work.

_____ Moderate limitation of functional capacity; capable of sedentary work.

_____ Severe limitation of functional capacity; permanently incapable of any kind of work.

What restrictions have you placed on the patient's activities? _____

3. Employability Status:

a. Is the patient **totally** and **permanently** disabled from gainful employment? Yes _____ No_____

b. Is the patient capable of performing sedentary employment? Yes _____ No_____

c. Is the patient capable of employment other than his/her last job? Yes _____ No_____

Additional Comments: _____

_____
Physician's Signature

_____
Date

Rule 60S-4.007, F.A.C.