SR-13e
Rev. 10/86
Disability Determination

State and County Officers' and Employees' Retirement System
Retiree's Report of Continuing Disability

PO Box 9000
Tallahassee FL 32315-9000
(850) 488-2968
Toll Free: 1-877-738-3725

Please Print or Type:

Retiree's Name:_____ Date:_____

Mailing Address:_____ SSN:_____

_____ Telephone #:_____

_____

A. INSTRUCTIONS: Please read carefully before completing this statement.

Section 122.09, Florida Statutes, provides that any officer or employee retiring under this section shall be examined periodically by a duly qualified physician or surgeon or board of physicians to determine if such total disability has continued. You are asked to complete Form SR-13e, Retiree's Report of Continuing Disability, and have a physician who is now treating or who last treated your disabling condition(s) complete the enclosed Form SR-13f, Physician's Report of Reexamination. When complete, both forms should be sent to the Division of Retirement, PO Box 9000, Tallahassee, FL 32315-9000. Should the physician charge for completing Form SR-13f, a copy of his bill must be attached to the forms so that the Division of Retirement can issue you a warrant to pay for such charges.

Please furnish the Division with the requested information within sixty (60) days from the date you receive these forms. In the event you cannot furnish this information within the sixty (60) days, notify the Disability Determination Section by writing the Division of Retirement or by calling 850-488-2968 or toll free at 877-738-3725.

B. **Medical Treatment Subsequent to Disability Retirement**

1. Since the date of your disability retirement or the date you last completed a Disability Evaluation Statement:

a. Have you received medical or therapeutic treatment of any kind?

☐ YES ☐ NO (If "Yes", please explain below)

_____

_____

_____

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B. **Medical Treatment Subsequent to Disability Retirement - continued**

b. Have you been under the regular care and supervision of a physician?

☐ Yes ☐ No (If "Yes", please explain below)

_____
_____
_____

c. Have you submitted to any surgical procedure?

☐ Yes ☐ No (If "Yes", please provide the date and type of surgery)

_____
_____
_____

d. Please provide the name and address of any physician, clinic or other medical or rehabilitative facility from whom you received treatment:

Date Treatment Received	Name of Physician or Institution	Address

C. **Employment Since Disability Retirement**

1. Since the date of your disability retirement or the date you last completed a Disability Evaluation Statement, have you ever been employed in any capacity?

☐ Yes ☐ No (If "Yes", please provide the information requested on the following page)

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1. Dates of Employment	2. Dates of Employment
Employer	Employer
Position Held	Position Held
Descriptions of Duties	Descriptions of Duties
Gross Annual Salary (show total for each year worked)	Gross Annual Salary (show total for each year worked)
Reasons for Terminating	Reasons for Terminating

2. Have you ever received disability benefits from Social Security, Workers' Compensation, Veterans' Administration, or any other public or private agency?

☐ Yes ☐ No (If "Yes", please list the source of those benefits received)

3. Have any of these disability benefits been terminated?

☐ Yes ☐ No (If "Yes", please specify and explain why)

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Present Condition

1. Do you feel you are still unable to perform the duties of the job you held prior to your disability retirement?

☐ Yes ☐ No (If "Yes", please specifiy and explain why)

2. Do you feel you are capable of engaging in any gainful employment?

☐ Yes ☐ No (If "No", please explain)

3. If you have any additional comments you wish to make concerning your present condition, please provide them in the following space. Should additional space be required, please attach a separate sheet.

I affirm that all information and statements provided on this form are true and correct to the best of my knowledge.

I hereby authorize any physician, hospital or clinic to give full and complete information concerning me or my medical condition including prior history to the Division of Retirement, Department of Management Services, State of Florida, or its authorized representative.

In addition to the above general medical release, I hereby specifically authorize the release of any records which may exist concerning me, including but not limited to employment records with previous employers, records with other Retirement Systems, with the Veteran's Administration, Social Security Administration, and any employment records, or personnel records with a School Board, Community College, Public School System, or any other records and reports which the Division may deem necessary in their investigation of my application for retirement and for which a personal release signed by me may be required.

Please cooperate fully with the bearer of this release.

(Date)

(Member)