SR-13a
Rev. 09/71
Disability Determinations

STATE AND COUNTY OFFICERS' AND EMPLOYEES RETIREMENT SYSTEM
STATEMENT OF DISABILITY

PO Box 9000
Tallahassee, FL 32315-9000
850-907-6500
Toll Free: 844-377-1888
Fax: 850-410-2010

SSN:_____

Date: _____

Name of Applicant: _____

Home Address: _____

Present Employer: _____

The applicant should state in detail in the spaces provided below the nature of his disability and the reason why he/she believes he/she is incapacitated for further service.

Regarding the nature of the disability which I claim incapacitates me for further service as _____
_____I believe I am incapacitated from further service because
(Title of Position)

_____

_____

_____

My disability ☐ is OR ☐ is NOT in-line-of-duty.

My family physician, Dr. _____
(Complete Name)

Address: _____

_____

advised me that _____

_____

_____

_____

_____

I authorize my physician to make report to the physician or physicians designated by you regarding my condition.

I can appear before the physician or physicians designated by you at such time and place as arranged by you.

_____
(Signature of Applicant)

STATEMENT TO BE RETURNED WITH APPLICATION