TR-13a
Rev. 10/86
Disability Determination

TEACHERS' RETIREMENT SYSTEM OF FLORIDA
STATEMENT OF DISABILITY

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

Date _____, 20 _____

SSN _____

FROM: 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 believes he 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 for further service because
(Give Title of Position)

_____

_____

_____

My family physician, Dr. _____ of _____
(Give Name in Full) (Give Address)

advises me that _____

_____

_____

_____

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

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