TR-13a
Rev. 10/86
Disability Determinations

**TEACHERS' RETIREMENT SYSTEM OF FLORIDA**
**STATEMENT OF DISABILITY**

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

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 the disability and the reason why he/she believes they are incapacitated for further service.

Regarding the nature of the disability which I claim incapacitates me for further service as a _____ 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**