

TR-13b
Rev. 10/86
Disability Determination

**TEACHERS' RETIREMENT SYSTEM OF FLORIDA
PHYSICIAN'S REPORT OF DISABILITY**

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

APPLICANT'S FAMILY PHYSICIAN MUST COMPLETE THIS FORM

Social Security No. _____

From: _____ M.D.

Date: _____

Address: _____

Telephone: _____

Subject: Physician's Report of Disability: Name of Applicant: _____

Home Address: _____

Present Employer: _____

This is to certify that _____ has been under my personal care since _____.
(Patient Name) (Date)

The subjective and objective symptoms of which said employee complains are as follows:

DIAGNOSIS: _____

TREATMENT: _____

PROGNOSIS: _____

In my opinion, by reason of the above described condition, the above named application (is) (is not) totally incapacitated for further performance of duty, (he) (she) is (likely) (not likely) to be incapacitated permanently and therefore (he) (she) (should) (should not) be retired.

Signed: _____ M.D.