TR-13b
Rev. 10/86
Disability Determination

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

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

APPLICANT'S FAMILY PHYSICIAN MUST COMPLETE THIS FORM

DATE _____

SSN _____

FROM: _____ M.D.

ADDRESS: _____

_____

_____

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) (Date)

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

DIAGNOSIS: _____

_____

_____

TREATMENT: _____

_____

_____

PROGNOSIS: _____

_____

_____

In my opinion, by reason of the above described condition, the above named applicant (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.