

Florida Retirement System
Physician's Report of Reexamination

PO BOX 9000 Tallahassee, FL 32315-9000
Local Phone: 850-907-6500 Toll Free: 844-377-1888 FAX: 850-410-2010

Patient Name: _____ SSN: _____

Authorization for Release of Medical Information

I am making application for continuation of disability retirement to the Florida Retirement System. I authorize my physician to release any information recorded on the examination report and any other pertinent facts and documents concerning my condition to the Florida Retirement System.

Patient Signature Date

Section A

License Number _____
Issued by State Board of Medical Examiners

Physician Name

Mailing Address

Specialty _____

Fax _____

Phone

Section B

1. Diagnosis:

a. Most recent examination date: _____

b. Diagnosed condition(s): _____

c. Subjective findings: _____

d. Objective findings: _____

e. Additional comments: _____

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Patient Name: _____ Patient SSN: _____

2. Physical and/or Mental Impairment:

- _____ No limitation of functional capacity; may return to work.
- _____ Slight limitation of functional capacity; capable of light work.
- _____ Moderate limitation of functional capacity; capable of sedentary work.
- _____ Limitation of functional capacity to the extent that the member is permanently prevented by reason of a medically determinable physical or mental impairment from rendering useful and efficient service as an officer or employee.

What restrictions have you placed on the patient's activities? _____

Additional Comments: _____

Physician's Signature

Date