FR-13a
Rev. 07/06
Disability Determination

Florida Retirement System
Statement of Disability by Employer

PO Box 9000
Tallahassee FL 32315-9000
(850) 488-2968
Toll Free: 1-877-738-3725
Fax: 1-850-410-2198

Applicant Name _____ Applicant SSN _____

Position Title _____

This form should be completed and signed by the designated person in your personnel office.

Date of Employment _____ Agency Name _____

Last Day Worked _____ _____

Last Day in Pay Status _____ _____

Termination Date _____ _____

Was the applicant able to perform all duties of this position prior to the illness or injury?

Yes ____ No ____

If not, please explain _____

_____

_____

Has the applicant discussed with your personnel office the possibility of moving into another position with your agency which would be within the applicant's medical limitations? Yes ____ No ____

If so, what positions were identified? _____

_____

_____

Why was this position not accepted? _____

_____

_____

_____

Type of disability: Regular ☐ In-Line-of-Duty ☐

Rule 60S-4.007, F.A.C.

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Applicant Name: _____ Applicant SSN: _____

If the applicant is applying for **in-line-of-duty** disability retirement please provide:

(1) A copy of the pre-employment physical examination, if any.

(2) Copies of all First Report of Injury or Notice of Injury Forms filed with Workers' Compensation or Risk Management.

(3) Copies of any Orders signed by a Deputy Commissioner, Rehabilitation Reports and medical documentation relative to the applicant's claim for in-line-of-duty disability.

Comments: _____

_____

_____

_____

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_____

_____

Authorized Signature: _____ Date: _____

Name (print): _____ Address: _____
Office Location

Title: _____ _____

Phone: _____ _____

_____