SR-13a
Rev. 09/71
Disability Determination

STATE AND COUNTY OFFICERS' AND EMPLOYEES' RETIREMENT SYSTEM

STATEMENT OF DISABILITY

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

SSN: ____________________________

Date: ____________________________

From: Name of Applicant: ____________________________

Home Address: ____________________________

Present Employer: ____________________________

The applicant should state in detail in the spaces provided below the nature of his disability and the reason why he believes he is incapacitated for further service.

Regarding the nature of the disability which I claim incapacitates me for further service as ____________________________ I believe I am incapacitated for further service because
(Give Title of Position)

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My disability (is OR is not) in-line-of-duty.

My family physician, Dr. ____________________________
(Give Name in Full)

Address: ____________________________

____

advises me that ____________________________

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I authorize my physician to make report to the physician or physicians designated by you regarding my condition.

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