FRESNO COUNTY
EMPLOYEES' RETIREMENT ASSOCIATION

APPLICATION FOR DISABILITY RETIREMENT

(Please type or print legibly in ink)

Board of Retirement
1111 H Street
Fresno, California 93721

Gentlemen:

PART A – PERSONAL INFORMATION

I have become permanently incapacitated for the performance of my duties in the position of _____

in the Department of _____

I hereby apply for:

☐ Service-connected disability retirement ☐ Non-service-connected disability retirement

NOTE: If the Board of Retirement finds that you are permanently incapacitated from the duties of your job, but that such incapacity did not arise out of your employment, the Board will consider your application as an application for a non-service-connected disability retirement you may appeal that decision. However, the finding of disability will not be binding upon the Board if appealed.

Yes ☐ I am willing to remain in service and accept a modified position with the County of Fresno which I could
No ☐ perform and which will not result in a loss of income to me.

Yes ☐ If final determination is not made upon my application for disability retirement within 90 days after I file my
No ☐ application and if I meet the minimum age and years of service eligibility requirements. I wish to be sent an application for a service retirement pending the determination of eligibility for disability retirement.

Name: _____

Other names used during County employment: _____

Social Security Number: _____

Address: _____
(No. Street, Apt. No.)

_____
(City) (State) (Zip Code)

Home Telephone No. ( )_____ Work Telephone No. ( )_____

Age:_____ Sex:_____ Birth Date: _____ Years of Service: _____

Date Last Worked: _____

Are you married at present: ☐ Yes ☐ No If yes:

Spouse's Name: _____ Social Security Number: _____

Spouse's Birth Date: _____ Date of Marriage: _____

Names and Birth Dates of children under 18 years of age: _____

_____

PART A – PERSONAL INFORMATION (Cont'd)

Current employment status with the County (check all items that apply to you);

- ☐ Working _____ hours per week.
- ☐ Sick Leave with compensation. Approximate date paid leave ends: _____
- ☐ Industrial leave with compensation. Approximate date paid leave ends: _____
- ☐ Resigned or terminated from County Service. Effective date: _____
- ☐ Sick leave without compensation. Date paid compensation ended: _____
- ☐ Other. Please specify: _____

☐ Application filed by **EMPLOYEE**

☐ Application filed by **EMPLOYER**

Department _____ Phone #_____

☐ Application filed by **other interested party**

If application is filed by interested party other than employee/member, provide the following information:

_____	_____	_____
Name and Title of Interested Party	Address	Phone

WARNING: Section 72 of the Penal Code provides:

"Every person who with intent to defraud, presents for allowance or for payment to any state board or officer, or to any county, city, or district board or officer authorized to allow or pay the same if genuine, any false or fraudulent claim, bill, account, voucher, or writing, is punishable either by imprisonment in the county jail for a period of not more than one year, by a fine of not exceeding one thousand dollars (1,000.00), or by both imprisonment and fine, by imprisonment in the state prison, by a fine of not exceeding ten thousand dollars (10,000.00) or by both such imprisonment and fine..."

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed this _____ day of _____ 20____ at _____ , California.

_____

Employee Signature

FRESNO COUNTY EMPLOYEES' RETIREMENT ASSOCIATION

APPLICATION FOR DISABILITY RETIREMENT

PART B – AUTHORIZATIONFOR RELEASE OF MEDICAL RECORDS

TO: _____ **(Applicant to leave this section blank)**

_____

_____

The purpose of this Authorization is to permit the investigation and processing of an application for disability retirement that I filed with the Fresno County Employees' Retirement Association (FCERA).

The undersigned hereby authorizes and requests you to permit FCERA any authorized agent thereof, to inspect and copy all records of whatever nature in your possession or under your control, without omission, pertaining to any physical or mental health care or examination I have received from any source, including (**but not limited to**) intake documents, personal history questionnaires, progress notes, Workers Compensation forms, job descriptions, excuse from work notes, return to work notes, all reports, diagnostic test results, correspondence, memoranda, and notes, whether typed or handwritten. Any *sub rosa* and investigation reports, from any and all persons having knowledge of pertinent facts, or facts which may lead to pertinent facts relating to disability application to FCERA or its agents. If any such records pertain to my psychological condition or use of alcohol, drugs, or other substances, their release is hereby specifically authorized.

To the extent that the confidentiality of any of these records may be protected by state or federal law, I waive the same because the records may be relevant to matters that are properly the subject of investigation by FCERA. I understand and acknowledge that records disclosed to FCERA pursuant to this authorization may be disclosed to individuals assisting FCERA to adjudicate my application for benefits, including interested parties, attorneys, independent medical examiners, hearing officers, court reporters and Board trustees. If an appeal of a Board action is filed with the Superior Court, I understand that such records may become part of the court file. I reserve the power to revoke this Authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this Authorization shall remain valid until the date of final determination of my disability retirement application except as authorized in Government Code Section 31729. I understand that I have the right to request and receive a copy of this Authorization.

A photocopy of this Authorization shall be as valid as the original.

Name: (please print) _____

Date of Birth: _____Social Security Number: _____

Signature: _____**Date:** _____

Witness Signature: _____**Date**:_____

FRESNO COUNTY EMPLOYEES' RETIREMENT ASSOCIATION

APPLICATION FOR DISABILITY RETIREMENT

PART B - AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS

TO: County of Fresno, Superior Courts of California – Fresno, Special Districts, and their departments

_____ **(Applicant to leave this section blank)**

_____

_____

The purpose of this Authorization is to permit the investigation and processing of an application for disability retirement that I filed with the Fresno County Employees' Retirement Association (FCERA).

The undersigned hereby authorizes and requests you to permit FCERA, and any authorized agent thereof, to inspect and copy all records of whatever nature in your possession or under your control, without omission, pertaining to any employment that I have held, including (without limitation) records relating to my employment application, hiring, job duties, job performance, hours worked, compensation paid, termination, injuries (either on the job or off), medical insurance, workers compensation claims, fitness for duty evaluations, leave applications, correspondence to/from my doctors, any investigative reports, any grievances, any meeting notes, memos, correspondence to/from me, any job descriptions, any requests for reasonable accommodation, any offers of reasonable accommodation, any letters of resignation, separation documents, etc. Any *sub rosa* and investigation reports, from any and all persons having knowledge of pertinent facts, or facts which may lead to pertinent facts relating to disability application to FCERA or its agents.

To the extent that the confidentiality of any of these records may be protected by state or federal law, I waive the same because the records may be relevant to matters that are properly the subject of investigation by FCERA. I understand and acknowledge that records disclosed to FCERA pursuant to this authorization may be disclosed to individuals assisting FCERA to adjudicate my application for benefits, including attorneys, independent medical examiners, hearing officers, court reporters and Board trustees. If an appeal of a Board action is filed with the Superior Court, I understand that such records may become part of the court file. I reserve the power to revoke this Authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this Authorization shall remain valid until the date of final determination of my disability retirement application except as authorized in Government Code Section 31729. I understand that I have the right to request and receive a copy of this Authorization.

A photocopy of this Authorization shall be as valid as the original.

Name: (please print) _____

Date of Birth: _____Social Security Number: _____

Signature: _____**Date:** _____

Witness Signature: _____**Date**:_____

FRESNO COUNTY EMPLOYEES' RETIREMENT SYSTEM

APPLICATION FOR DISABILITY RETIREMENT

PART B: AUTHORIZATION FOR RELEASE OF WORKERS' COMPENSATION RECORDS

TO: County of Fresno, Superior Courts of California – Fresno, Special Districts, and their departments, agents, or third party administrators

The purpose of this Authorization is to permit the investigation and processing of an application for disability retirement that I filed with the Fresno County Employees' Retirement System (FCERA).

The undersigned hereby authorizes and requests you to permit FCERA, and any authorized agent thereof, to inspect and copy all records of whatever nature in your possession or under your control, without omission, pertaining to my **Workers Compensation claims** including (**but not limited to**), subpoenaed medical records, treating physician medical records, all P & S reports, all IME, QME or AME medical reports and records, all *sub rosa* reports and surveillance video, all fitness for duty examination reports, all pre-employment and periodic health examinations, all Workers Compensation claim forms, all claimant deposition transcripts, all physician deposition transcripts, all witness statements, all witness disposition transcripts, all investigative reports, all excuse from work notes, all return to work notes, all correspondence to/from physicians, all job descriptions, all job analysis reports, all RU 91 forms, all RU 94 forms, all written offers of modified work or offered reasonable accommodations, all vocational rehabilitation notes and reports, all C & R agreements, all Findings and Awards documents, etc. If any such records pertain to my psychological condition or use of alcohol, drugs, or other substances, their release is hereby specifically authorized.

To the extent that the confidentiality of any of these records may be protected by state or federal law, I waive the same because the records may be relevant to matters that are properly the subject of investigation by FCERA. I understand and acknowledge that records disclosed to FCERA pursuant to this authorization may be disclosed to individuals assisting FCERA to adjudicate my application for benefits, including attorneys, independent medical examiners, hearing officers, court reporters and Board trustees. If an appeal of a Board action is filed with the Superior Court, I understand that such records may become part of the court file. I reserve the power to revoke this Authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this Authorization shall remain valid until the date of final determination of my disability retirement application except as authorized in Government Code Section 31729. I understand that I have the right to request and receive a copy of this Authorization. A photocopy of this Authorization shall be as valid as the original.

A photocopy of this Authorization shall be as valid as the original.

Name: (please print) _____

Date of Birth: _____Social Security Number: _____

Signature: _____**Date:** _____

Witness Signature: _____**Date**:_____

FRESNO COUNTY EMPLOYEES' RETIREMENT ASSOCIATION

APPLICATION FOR DISABILITY RETIREMENT

PART C – SUPPLEMENTAL QUESTIONS

(attach additional sheets, if necessary)

1. Describe specifically the injury or illness that you claim is causing you to be permanently disabled from performing your job duties.

2. How and where did the injury or illness occur? (Please answer completely.)

3. On what date were you injured or did you first notice that you were ill?

4. If your disability is the result of a job-related injury (or injuries) or a job-related disease or illness, list all witnesses. Give names, work locations, phone numbers and addresses of the witnesses.

5. Describe the duties to which you were assigned and which you actually performed at the time your disability arose.

PART C – SUPPLEMENTAL QUESTIONS (Cont'd)

6. State specifically, and in detail, the duties that you cannot perform because of your disability.

7. Have you ever received treatment for a SIMILAR injury or illness?

☐ Yes ☐ No If yes:

a. Give the dates of treatment.

b. Give the names and addresses of the treating doctors, hospitals or clinics.

PART C – SUPPLEMENTAL QUESTIONS (Cont'd)

8. Are you presently employed, part-time or otherwise, by anyone other than the County of Fresno, Courts, Special Districts or self-employed ? ☐ Yes ☐ No

   If yes, list the employer's name (including self employment), address, phone number, and your job duties.

   _____

   _____

   _____

   _____

   _____

9. List all branches of the military service in which you served, where stationed and when.

   _____

   _____

   _____

10. List all employers (including other County departments, Courts, and Special Districts) for whom you have worked in the last 10 years. Include addresses, telephone numbers, periods of employment and names of all supervisors.

    _____

    _____

    _____

11. **List the names, addresses and telephone numbers of all doctors** or other individuals consulted for diagnosis or treatment relating to the subject injury or disease. Include the approximate dates of consultation, if known. Please include any doctors with whom you have appointments scheduled in the future for additional medical services that pertain to this injury or disease. List the dates of the future appointments.

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

PART C – SUPPLEMENTAL QUESTIONS (Cont'd)

12. Are you now or have you ever received any kind of disability benefits, including pension, awards or medical compensation for this or any other injury or illness?

☐ Yes ☐ No If yes, give details.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

13. Have you applied for Workers' Compensation for this or any other injury or illness?
☐ Yes ☐ No If yes, state the date(s) the application(s) was/were filed.

_____

_____

_____

14. Have you requested reasonable accommodations to enable you to perform your duties within your permanent medical restrictions? ☐ Yes ☐ No If yes, were they successful?

_____

_____

_____

15. Do you have any ideas for modifications that would permit you to be able to perform your usual duties?

_____

_____

_____

16. Include any further information you might offer to help the Board of Retirement in determining your disability.

_____

_____

_____

PART C – SUPPLEMENTAL QUESTIONS (Cont'd)

17. Will you be represented in this application for disability retirement by an attorney?

☐ Yes ☐ No If yes, include Attorney's name address and telephone number.

_____

_____

18. I will provide the names and addresses of any medical providers who see me subsequent to the date of this application. I will also provide FCERA with any information that changes, adds to, or modifies any of my responses given above as soon as I receive such information.

19. If in the future, I am employed, part-time or otherwise, by anyone, or self-employed, I will provide the name and address, phone number, and job duties of associated with employment.

20. **I understand and acknowledge that this Application of Disability Retirement will not be deemed fully complete nor accepted for processing by FCERA unless and until I provide a completed Part D Physician's Statement** prepared by a licensed physician or psychologist who has treated me for the condition(s) that is the subject of this application. I understand that any cost associated with the completion of Part D is my responsibility. I further understand that if I do not obtain a completed Part D promptly, that my application may be untimely which may cause me to lose my rights to a disability retirement, pursuant to Government code, Section 31722. I understand that Government Code, section 31722 provides that my application shall be made while I am in service, within four months after I discontinue service, within four months after expiration of any period during which a presumption is extended beyond my discontinuance of service, or while, from the date of discontinuance of service to the time of my application, I am continuously physically or mentally incapacitated to perform my job duties.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed this_____ day of_____, 20_____, at _____, California.

_____

Employee Signature

_____

*Authorized Employee Signature

_____ _____

*Title *Date

**Required only when department files on behalf of employee.*

FRESNO COUNTY EMPLOYEES' RETIREMENT ASSOCIATION

APPLICATION FOR DISABILITY RETIREMENT

PART D - TREATING PHYSICIAN'S STATEMENT

TO THE TREATING PHYSICIAN: To determine whether your patient meets the requirements for a disability retirement under the County Employees Retirement Law, the Retirement Board will consider the information that you provide in this statement along with information contained in your treating records and the records of other evaluating medical professionals. If additional space is needed, please add pages, numbering the item you are answering. All questions must be fully answered and understandable by a non-medical professional to be deemed complete. (attach additional sheets if necssary)

Patient Name _____

Physician Name_____ Physician Phone _____

Physician Address_____ _____

1. How long have you treated this patient? _____Frequency? _____

2. Identify the disabling condition(s), if any: _____

_____

A. Is the patient's claimed disability due to intemperate use of alcohol or drugs? ☐ Yes ☐ No
B. Is the patient's claimed disability due to willful misconduct? ☐ Yes ☐ No

3. Based upon the review of the patient's job description, please list the permanent restrictions/limitations required by the patient as a result of the claimed disability. If this claim is based upon more than one condition, please match the required restriction/limitation with the corresponding claimed disability. Please be specific.

_____

_____

4. Is the Applicant permanently incapacitated from performing his/her job duties? ☐ No ☐ Yes

A. Do you expect a change in the patient's claimed disability?

☐ No

☐ Yes, for the better. Please explain and include anticipated timeframe for change:

_____

☐ Yes, for the worse. Please explain and include anticipated timeframe for change:

_____

5. Is there any treatment that might permit the patient to return to duty?

☐ No

☐ Yes, please describe the treatment, its availability and acceptance in the medical community. Also please estimate the time and requirements for a recovery and advise whether the benefits of treatment clearly outweigh the risks of treatment::

_____

_____

FRESNO COUNTY EMPLOYEES' RETIREMENT ASSOCIATION

APPLICATION FOR DISABILITY RETIREMENT

PART D - TREATING PHYSICIAN'S STATEMENT (Cont'd)

6. List any permanent work restrictions:

_____

_____

7. What, if any, is the connection between the patient's claimed disability and his/her employment ?

_____

_____

_____

****Do not complete "Delayed Disability" section below if applicant is still actively employed****

Delayed Disability application affidavit. This section must be completed by the member's physician if the application is not filed within four (4) months of discontinuance of service.

Was the applicant continuously physically or mentally incapacitated from performing his/her duties from the end of the discontinuance of service to current date? ☐ Yes ☐ No

Did the incapacitation exist at the time of the discontinuance? ☐ Yes ☐ No

Please provide a copy of all documentation relied upon to conclude that the patient has been continuously incapacitated.

Penalty of perjury statement

I declare under penalty of perjury that the information contained in this questionnaire and its attachments, if any, are true and correct to the best of my knowledge and belief, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

Printed Name: _____ Date_____

Signature:_____ Medical ID Number _____

Mailing Address: _____

Return signed physician's statement and documentation to:

FCERA
1111 H Street
Fresno, CA 93721